2010/11 ANNUAL UPDATE **EXHIBIT A**

COUNTY SUMMARY SHEET

This document is intended to be used by the County to provide a summary of the components included within this annual update or update. Additionally, it serves to provide the County with a listing of the exhibits pertaining to each component.

County:	***El Dorado***																				
			Exhibits																		
			A	**B**	**C**	**C1**	**D**	**D1***	**E**	**E1**	**E2**	**E3**	**E4**	**E5**	**F****	**F1****	**F2****	**F3****	**F4****	**F5****	**G*****	**H******
For each annual update/update:			☑	☑	☑	☑			☑													
Component	**Previously Approved**	**New**																				
☑ CSS	$5,265,407	$4,588,048				☑	☑	☑		☑					☐	☐					☐	☐
☑ WET	$310,500	$363,682				☑	☑	☑			☑				☑	☑						
☐ CF	$	$						☐				☐			☐		☐					
☐ TN	$	$						☐				☐			☐			☐				
☑ PEI	$ 635,998 (6 months)	$2,018,644				☐	☑	☐					☑		☑				☑			
☐ INN							☐	☐						☐	☐					☐		
Total	$ 6,211,905	$ 6,970,374																				

Dates of 30-day public review comment period:	August 6, 2010 - September 6, 2010
Date of Public Hearing***:**	Tuesday, September 07, 2010
Date of submission of the Annual MHSA Revenue and Expenditure Report to DMH:	**6/30/2010**

*Exhibit D1 is only required for program/project elimination.

**Exhibit F - F5 is only required for new programs/projects.

***Exhibit G is only required for assigning funds to the Local Prudent Reserve.

****Exhibit H is only required for assigning funds to the MHSA Housing Program.

*****Public Hearings are required for annual updates, but not for updates.

COUNTY CERTIFICATION

County: El Dorado

County Mental Health Director	Project Lead
Name: Neda West Telephone Number: 530-621- 6156 E-mail: Neda.West@edcgov.us	Name: Chris Kondo-Lister Telephone Number: 530-621-6290 E-mail: Christine.Kondo-Lister@edcgov.us
Mailing Address: El Dorado County Health Services Administration 931 Spring Street Placerville CA 95667	

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations, laws and statutes for this annual update/update, including all requirements for the Workforce Education and Training component. Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

This annual update has been developed with the participation of stakeholders, in accordance with sections 3300, 3310, subdivision (d), and 3315, subdivision (a). The draft FY 2010/11 annual update was circulated for 30 days to stakeholders for review and comment and a public hearing was held by the local mental health commission. All input has been considered with adjustments made, as appropriate.

The County agrees to participate in a local outcome evaluation for the PEI program(s) identified in the PEI component.[1]

The County Mental Health Director approves all Capital Facilities and Technological Needs (CFTN) projects.

The County has complied with all requirements for the Workforce Education and Training component and the Capital Facilities segment of the CFTN component.

The costs of any Capital Facilities renovation projects in this annual update are reasonable and consistent with what a prudent buyer would incur.

The information provided for each work plan is true and correct.

All documents in the attached FY 2010/11 annual update/update are true and correct.

Neda West _____ _____

Mental Health Director/Designee (PRINT) Signature Date

[1] Counties with fewer than 100,000 residents, per Department of Finance demographic data, are exempt from this requirement and may strike this line from the certification.

HEALTH SERVICES DEPARTMENT

MENTAL HEALTH DIVISION

Treatment Works, People Recover
El tratamiento es efectivo, las personas se recuperan

Neda West, Director / Christine Kondo-Lister, LCSW, Deputy Director
670 Placerville Drive, Suite 1B, Placerville, CA 95667 (530) 621-6200 / Fax (530)295-2639

Mental Health Services Act (MHSA)
FY 2010/11
Administrative Costs

The County of El Dorado is submitting FY 2010/11 MHSA Plan Update documents representing a total funding request of $6,970,374, described below. As specified in DMH Information Notice 10-09, page 9, this document serves as a signed statement which accompanies the County's request for administrative costs above 15 percent (15%) of the total direct program costs.

1) The Community Services and Supports (CSS) Annual Update includes a request for funding in the amount of $3,260,500 combined with FY 2010/11 carryover funds of $1,327,548 for a total plan amount of $4,588,048. The total combined funds are requested to be allocated as follows:
    - Program Plan: $3,342,110
    - County Administration: $828,843
    - Operating Reserve: $417,095

2) The Workforce Education and Training (WET) Annual Update includes a request for funding in the amount of $363,682. The total combined funds are requested to be allocated as follows:
    - Program Plan: $261,981
    - County Administration: $68,639
    - Operating Reserve: $33,062

3) The Prevention and Early Intervention (PEI) Annual Update includes a request for funding in the amount of $2,018,644. The total combined funds are requested to be allocated as follows:
    - Program Plan: $1,595,766
    - County Administration: $239,365
    - Operating Reserve: $183,513

County administrative costs exceed the recommended funding limit of 15% in both the CSS and WET plan, as follows:

- CSS county administrative costs of $828,843 represent 24.8% of program costs
- WET county administrative costs 0f $68,639 represent 26.2% of program costs

Administrative costs for the county's PEI plan are maintained within the 15% recommended funding limit because that plan contains a high proportion (approximately 38%) of subcontracted serves. In contrast, subcontracted services account for less than 5% of the CSS and WET program budgets. Additionally, administrative costs in the County of El Dorado may be high relative to some other California counties because of our smaller size. Representatives from small counties have in the past discussed the recommended funding limit of 15% for administration costs and several counties have

experienced that this percentage is inadequate to fund their true administrative costs. In the past, representatives from the State have acknowledged that there may be merit to the argument that small counties require a larger percentage for administrative costs.

The administrative costs allocated to El Dorado County's MHSA program for FY 2010/11 were derived using methodologies consistent with both DMH Letter No. 05-10 and with former OMB A-87 Federal Register (now Title 2, Federal Regulations (CFR), Subtitle A, Chapter ii, Part 225). Also, Welfare and Institutions Code Section 5891 states, "The state shall not make any change to the structure of financing mental health services, which increases a county's share of cost or financial risk for mental health services unless the state includes adequate funding to fully compensate for such increased costs or financial risk." In consideration of these guidelines and regulations, the County respectfully requests approval for an allocation in excess of the 15% recommended for FY 2010/11.

In summary, this document serves to verify that:

- The additional county administrative costs are based on an acceptable allocation method, consistently applied by the county in similar circumstances, which allocates an increased share of costs to the MHSA funding stream in proportion to the benefit to the program/project; and,
- That these costs do not violate the requirements of Welfare and Institutions Code section 5891, subdivision (a), and California Code of Regulations section 3410.

Neda West _____ _____

Mental Health Director Signature Date

COMMUNITY PROGRAM PLANNING AND LOCAL REVIEW PROCESS

County: El Dorado

Date: September 28, 2010

Instructions: Utilizing the following format please provide a brief description of the Community Program Planning and Local Review Processes that were conducted as part of this annual update/update per title 9 of the California Code of Regulations, sections 3300 and 3315.

Counties may elect to attach the Mental Health Board meeting minutes in which the annual update was discussed if it provides additional information that augments the responses to these questions.

Community Program Planning
1. Briefly describe the Community Program Planning (CPP) Process for development of the FY 2010/11 annual update/update. Include the methods used to obtain stakeholder input.
MHSA Community Meetings and Advisory Meetings were held twice since the last MHSA Annual update was approved. Updates regarding plan progress, anticipated changes, budget issues and future planning were discussed. In addition, Community Program Planning (CPP) targeted focus groups were conducted and included updates and inquiries regarding previously approved plans, as well as components pending an approved plan. MHSA updates and discussions have also taken place in the Mental Health Division (MHD) Leadership Teams and the three Clinical Treatment Teams. Finally, MHSA updates and discussions have taken place as part of the Mental Health Commission meetings both in Placerville and South Lake Tahoe.
2. Identify the stakeholder entities involved in the Community Program Planning (CPP) Process.
The general public are invited to the MHSA Community Meetings; the MHSA Advisory Committee is represented by the County Office of Education, Shingle Springs Rancheria, consumer and family members, Calworks program, NAMI, Public Health Division, Marshall Medical Center, Community Health Center, Alcohol and Drug Treatment Programs, Center for Violence-free Relationships, Probation Department, Sheriff's Department, Foster Parent Association, Family Resource Center, 1st Five, and Department of Human Services. The representatives who participated in the most recent CPP planning process included Mental Health Division staff, NAMI, the Mental Health Commission, local Community Strengthening Groups, El Dorado Hills community representatives, Georgetown Divide community representatives, PFLAG, SPEAR, Center for Violence-free Relationships, Senior Peer Counseling, Peer Counselors, and Human Services Ombudsman.
3. If eliminating a program/project, please include how the stakeholders were involved and had the opportunity to participate in the decision to eliminate the program/project.
The proposal and rationale to eliminate the MHSA Loan Assumption, BHC Client Outcomes, and unfunded programs under WET were discussed at the MHSA Community Meetings, MHSA Advisory Meetings, and Mental Health Commission meetings and the MHD Leadership Meetings.
Local Review Process
4. Describe methods used to circulate, for the purpose of public comment, the annual update or update.
The Annual Update was posted on the Mental Health Division website on August 6, 2010 for a 30-day review period. E-mail notifications were sent to a 400-member MHSA e-mail group, the Mental Health Commission members, the Chief Administrative Office (CAO), the Board of Supervisors' offices, the MHSA Advisory Committee members, and the Mental Health Division staff. The notification on the e-mail and on the web-site indicated that feedback and/or questions could be submitted via e-mail, regular mail, or to a specific phone line. Further, details regarding the Public Hearing were also provided as a venue for providing feedback. The Public Hearing was scheduled to be hosted by the Mental Health Commission on Tuesday, September 7, 2010 at 12 pm at the Public Health Division facilities both in Placerville and South Lake Tahoe via teleconference.

COMMUNITY PROGRAM PLANNING
AND LOCAL REVIEW PROCESS

5. Include substantive comments received during the stakeholder review and public hearing, responses to those comments, and a description of any substantive changes made to the proposed annual update/update that was circulated. The County should indicate if no substantive comments were received.

Public Hearing regarding the El Dorado County MHSA Plan Update for FY 2010-11
Summary of Community Discussion – September 7, 2010.

The El Dorado County Mental Health Commission hosted a public hearing on Tuesday, September 7, 2010 regarding the County's MHSA Plan Update. The hearing was held from 12:00 – 1:00 p.m. in the Public Health/EMS teleconference rooms at 415 Placerville Drive, Suite K in Placerville and 1360 Johnson Blvd #103 in South Lake Tahoe. Notice of the meeting was posted on the County website (http://www.edcgov.us/mentalhealth/mhsa.html), and press releases were sent to the following local newspapers:

- Mountain Democrat
- Sacramento Bee
- Tahoe Tribune
- Life Newspapers
- El Dorado Hills Telegraph
- Georgetown Gazette

In addition, e-mail notifications of the Public Hearing date, time and place were sent to:

- MHSA e-mail group
- Mental Health Commission
- MHSA Advisory Committee
- Board of Supervisors
- Chief Administrators Office
- Mental Health Division staff

Twelve (12) people attended the meeting and Lisa Shafer, chair of the South Lake Tahoe MH Commission, presided. The following is a summary of the public discussion.

Question /Comment

The Mental Health Commission has reviewed the MHSA Plan Update and issued two specific recommendations:

- The Commission is recommending changes in the Life Skills modules that are available to clients, specifically transitioning away from the modules currently in use and suggesting that other teaching materials – including those developed at Boston University - be explored and adopted; and,
- The Commission is recommending that the Plan Update include a renewed focus on enrichment activities for clients who reside in Board-and-Care facilities.

Ensuing Discussion

On behalf of the Mental Health Commission, Lisa Shafer noted that an assessment of groups, including those focused on Life Skills, had been done in South Lake Tahoe as part of the Commission's 2010 Annual Report[1]. The assessment found that clients were dissatisfied with the Life Skills modules, and at that time the Commission recommended that the MHD investigate other formats for the group process.

[1] El Dorado County Mental Health Commission 2010 Annual Report is available in the BOS agenda item 10-0350, 5/04/2010

COMMUNITY PROGRAM PLANNING
AND LOCAL REVIEW PROCESS

Chris Kondo-Lister described alternate models currently being considered or implemented, including an Anger Management group and "Seeking Safety," an evidence-based group model for addressing substance abuse and trauma-related issues.

Please see WET Action #3 which now reflects changes to include a focus on the Psychiatric Rehabilitation Training approach out of Boston University.

Question/Comment
One individual commented on the importance of the PEI component. She noted that prevention and early intervention is extremely critical especially with regard to co-occurring disorders, adding that the use of drugs and alcohol can trigger a psychotic break.
Ensuing Discussion
There was general agreement that the services provided under the PEI plan, with their focus on youth and preventative programs, were needed, important and appreciated.

Question/Comment
Another individual commented on the difficulty experienced in trying to navigate the MHSA documents and expressed the hope that the Mental Health Commission would be kept informed and included early in the development process for future MHSA plans and updates.
Ensuing Discussion
Chris Kondo-Lister provided a timeline for the MHSA Plan Update for FY 2011-2012 (expected to begin after the first of the year and target a posting date of March 2011). She also outlined the planned development of an additional MHSA plan for Housing (with community meetings to start in September), as well as future planning for MHSA Innovation and Capital Facilities/Technology funds.

Question/Comment
A question was asked about the availability of MHD contracts with other providers of mental health services. The individual wanted to know if, when and where the terms of those contracts are available to the Mental Health Commission.
Ensuing Discussion
Chris Kondo-Lister explained that contracts which exceed a set dollar amount must be approved by the Board of Supervisors and are posted prior to approval on the BOS website. Brenda Bailey, a staff member in the office of the Board of Supervisors, added that the public can subscribe to receive regular updates to the Board agenda and minutes. She suggested that training in how to access and navigate the BOS website might be helpful, and Chris Kondo-Lister offered that such training could be provided at a future meeting of the MH Commission.

Question/Comment
A question was asked about the likelihood of a Board-and-Care facility being established in El Dorado County.
Ensuing Discussion
Chris Kondo-Lister described trying to work with a very well established provider of Board-and-Care facilities in Sacramento County. In this case, bringing a Board-and-Care facility to El Dorado County was not feasible due to both practical and financial issues. The MHD has been working with Transitional Homes in the County, and although these are different from Board-and-Care facilities, they do provide needed housing options for some of our clients. In addition, the MHD is

beginning discussions necessary to bring permanent, supported housing to El Dorado County through the use of MHSA Housing funds.

In addition, the following feedback was received during the 30-day Public Review and Comment Period:

August 23, 2010 – a list of questions was submitted by a subcommittee of the Mental Health Commission. The following is a list of the questions and the MHD responses:

Comments:
The WS and SLT Councils have delegated five members of the EDC Mental Health Commission to begin the process of carrying out our duties under Article IX of our Bylaws. We met at Lake Tahoe Community College on August 19, 2010. At that meeting and subsequently, each member of the committee has reviewed those documents available to us now.

Each member of the committee has communicated to me via e-mail some findings and questions.

We find that the documents do [not] contain enough information to enable us, or any reader, to know what outcomes are associated with any proposed contract. We acknowledge that there may be many other documents that spell out these outcomes, but we have not seen them.

We cannot determine from the documents available how *anyone* could determine, in terms of operational definition, what a contractor is contracted to accomplish for the money. Levels of effort, or the maximum hours that can be billed, is inadequate information, and not satisfactory to us. Most of the text wording is general, vague, and nonspecific. The Department may have operationally defined criteria for measuring performance, but none of the documents reviewed specify them. Invoices billing for hours is not the kind of outcome we are writing about.

The committee has named me as their chair, and asked me to collate their questions and present them to you, with the expectation that significant clarification will be forthcoming in time for the August 25 teleconference, or as soon thereafter as feasible.

It has been suggested to me that the wording in the documents that we have had a chance to see are *supposed* to be general, vague, and nonspecific, as they are to fulfill some State format, and are not intended to communicate what a contractor is actually to achieve in performance of their contract. If that be the case, then there must be other documents that would enable measuring contractor performance in terms of operationally defined outcomes. The term "evidence-based" has been employed in talking about mental health projects and practices. I stand by my request that we apply this concept to contractor performance. I affirm that some members have explicitly told me that they cannot tell what the contractor is actually supposed to be doing and achieving in exchange for the contract dollars.

Response:
The information and language used in the MHSA Plan Update draft is intended to address the questions posed in the required State Department of Mental Health (DMH) application for the FY 10-11 MHSA allocation of funds. Specific contract requirements and performance measures will be articulated in Service Agreements or Contracts proposed by the Mental Health Division (MHD), and upon approval of the County's MHSA Plan Update, approved and executed by the County of El

Dorado Purchasing Agent or Board of Supervisors.

In regard to evidence-based practices, while the MHSA strongly encourages application of these strategies, they are not required for all intervention strategies funded with these dollars.

For example:

1) Use of MHSA funds to pay for outreach and engagement services often will not involve evidence-based practices, but outreach and engagement is highly encouraged to increase access and decrease disparities;
2) The Wraparound program for youth that was highly encouraged under the CSS program was a Promising Practice at the time and some consider a Best Practice at this time – it has not yet been measured as an Evidence-based Practice; and,
3) Support for the use of culturally-specific strategies within various communities is encouraged yet many of these strategies are not considered “evidence-based”.

Therefore, the general expectation that contract providers, as well as the MHD, apply use of evidence-based practices in MHSA-funded programs is an appropriate and shared goal – but not an absolute requirement.

Comments:
CSS - "Other disciplines and community-based agencies" needs to be fully spelled out in detail. Specifically, how is the money requested for CSS to be used? What are the outcomes?

Response:
The reference speaks to the desire to continue to develop the Wellness Center to serve as a community-building force that is inclusive, normalizing, and holistic in supporting behavioral health recovery. While this effort may include contracting out services (to date, CSS funds contracts for vocational rehabilitation with Crossroads), many desired partnerships may entail in-kind support, pro-bono work, and volunteerism. The intended outcomes are community-capacity building, increased access to services, user-friendly one-stop model of service delivery, and the application of a whole person and community-integration approach.

For example:

- Human Services providing Benefits Screening.
- Social Security providing outreach and education regarding SSI.
- Public Health providing health education and screening.
- Drug and Alcohol Program providing prevention and education.
- 12 Step Groups

Comments:
P.E.I. Program 1. What does "expansion of the mechanisms for referral and access" mean in terms that we can fully understand? "Referrals from additional sources . . . ." Precisely, what are these additional sources? How many individuals are expected to be beneficiaries of the services budgeted for $319,768?
Response:
“Referrals from additional sources will be entertained.” on page 1 of the PEI plan was added to include sources of referral into the program beyond school personnel. Other potential sources of referral might include clinicians and other community organizations and agencies that serve families

in need. For the fiscal year, an estimate of 55 individuals will be served.

Comments:
PEI Program 2. Budgeted for $237,830. Which are the schools to be involved, and how many expected recipients in each named school?

Response:

School & Location	Number of Children Expected to Participate
Oak Meadow Elementary School, El Dorado Hills	42
Northside School, Cool	42
Georgetown School, Georgetown	42
Bijou Community School, South Lake Tahoe	60
Lake Tahoe Environmental Science Magnet School, South Lake Tahoe	30
Sierra House Elementary School, South Lake Tahoe	30
Tahoe Valley Elementary, South Lake Tahoe	60

Comments:
PEI Program 3. What are the specific sites, and how many intended beneficiaries?

Response:

Incredible Year (IY) Sites & Location	Number of Expected Participants (Families)
Independence High School, Diamond Springs	35
Mount Tallac Continuation School, South Lake Tahoe	10
Tahoe Tot Spot, South Lake Tahoe	10
White Rock Village Apartments, El Dorado Hills (2 sessions)	24
Union Mine High School, El Dorado	15

Comments:
PEI Program 4. In operationally defined terms, what outcomes are intended for this project? Describe the various users of the project in terms of computer skills and aptitudes needed.

COMMUNITY PROGRAM PLANNING
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Response:
There are several components that make up Program 4:

a) Parenting Wisely Program (Selective and Indicated Prevention Approaches) This parent training program targets parents with children ages 5-18. The Parenting Wisely Program uses a self-administered, interactive and multimedia CD-ROM as the training vehicle and thereby overcomes illiteracy and transportation barriers. Usage involves very limited computer skills; participants insert the DVD and follow guidelines provided on-screen.

b) NAMI training capacity building (Selective and Indicated Prevention Approaches)
The National Alliance on Mental Illness (NAMI) serves to provide awareness, education and advocacy as a means to offer hope, reform and health to the community. This group began in 1979 and represents families, friends and individuals affected by mental illness. The local NAMI chapters have been successfully providing the Family to Family Program (a 12-week course provided to families, friends, and caregivers and community members) by NAMI volunteers free of cost. This program does not require any computer skills.

c) PFLAG Community Education (Universal, Selective and Indicated Prevention Approaches)
As an approved PEI program under Community Education, the MHD is partnering with Parents, Families, Friends of Lesbians and Gays (PFLAG) to provide outreach, education and training to mental health providers and interested community members. PFLAG provides an opportunity for dialogue about sexual orientation and gender identity and acts to create a society that is healthy and respectful of human diversity. Their mission is to support diversity, community involvement to build understanding, education to reduce stigma, and advocacy to end discrimination. This program does not require computer skills.

d) Community Information Access
Under this program, a Community Access Site (CAS) or web-based community education and information resource center for consumers of mental health services, family members and community stakeholders will be initiated, as well. This community referral site provides free access to a comprehensive library of interactive online courses targeting the general public.

Topics include:
- General mental health
- Addiction, treatment and recovery
- Issues facing families
- Needs of children and adolescents
- Living with mental illness and working toward recovery
- Workforce skills – including basic computer training
- Issues related to older adults
- Needs of returning veterans
- WRAP information Center.

This program requires limited computer skills to navigate the website.

e) Consumer Leadership Academy
This program will include a Leadership Academy providing educational opportunities designed to inform and empower consumers in relationship to meaningful participation in the broader community.

COMMUNITY PROGRAM PLANNING
AND LOCAL REVIEW PROCESS

This program has begun locally as a grassroots effort with very favorable response on both slopes. Consumers have identified a need for support related to transportation assistance, funding for food during activities, and training resources and fees. In addition, funding and the establishment of a stipend program to address costs incurred for participants will be pursued. One desired outcome is increased participation on the Mental Health Commission. Training will also be pursued through the California Institute on Mental Health (CIMH) for Mental Health Board Trainings and through the MHSA WET Regional Collaborative for the Recovery-Oriented Leadership series. Peer counselor training may also be included in future Leadership Academy training events.

For the Consumer Leadership Academy activities, transportation assistance for county-wide events will be made available on a quarterly basis. Healthy snacks will be funded for locally held monthly consumer meetings at both SLT and WS. Staff support for a range of these events will be provided, as well. The WET Coordinator, Patients Rights Advocate, and Volunteer Coordinators, and Mental Health Aides on both slopes will collaborate with consumers on this project. A meaningful role in the community may serve to be one of the most effective preventive measures to avoid relapse to illness.

This section of the plan will not require the use of a computer.

f) Mental Health First Aid
The MHD proposes to engage the local community and participate in a training program sponsored by the Central Region Collaborative to establish community Mental Health First Aid Trainers. These individuals will attend a weeklong training fully funded by the Central Region MHSA WET funds and return to the County to provide the training described below.

The Mental Health First Aid program is an interactive session which runs 12 hours and provides certification which must be renewed every three years. This training introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and provides an overview of common treatment modalities. Mental Health First Aid is designed to give members of the public key skills to help someone who is developing a mental health problem or experiencing a mental health crisis. The evidence behind the program demonstrates that it does build mental health literacy and helps the public to identify, understand and respond to signs of mental illness.

Intended Outcomes:
Mental Health First Aid in the US can become as common as CPR and First Aid. It has the potential to reduce stigma, improve mental health literacy, and empower individuals. As such, it has great potential as a community capacity building educational strategy. Staff and community members will be invited to become trainers and develop a county training plan.

Computer literacy is not required for this program.

Comments:
Program 5. Budgeted for $116,865. Define operationally the outcomes expected.

Response:
This project, Wennem Wadati – A Native Path to Healing, targets the PEI target population of *children and youth in stressed families* and, as such, is intended to address the community mental health

needs surrounding *at-risk children, youth and young adults*. This program was designed by and for the local Native American community thereby addressing the community mental health need of disparity in access. As a comprehensive program serving youth and families and individuals of all ages, this program also addresses populations of trauma-exposed individuals and children and youth who are at risk for school failure and at risk of juvenile justice involvement. Finally, given the disproportionately high rates of suicide among this population, this culturally-specific program is designed to address a high-risk population.

Mental Health Prevention Goal – Mental health promotion through a combination of mental health services and traditional cultural teachings unique to the local Native American community.

Approach -Universal, Selective, and Targeted Prevention.

Intervention Strategy/Model:
Native Americans suffer from a disproportionate level of health-related problems and shorter life spans. Traumatic stress issues, depression, anxiety and low self-esteem are focal issues in the management of self-care among Native American families. As such, a community and culturally-based PEI program serves as a critically needed strategy.

The Native American Resource Collaborative (NARC) has been working together toward the development of an innovative community-based approach to address alcohol, substance abuse, and mental health issues that is integrated and shaped by the values and traditions of Native Americans and their cultures. Another identified need was for a centralized location for Native American youth and families to get information about resources and how to access them.

Wennem Wadati – A Native Path to Healing applies a combination of mental health early intervention strategies, traditional cultural teachings, and crisis intervention support for youth within the public school system. Specifically, this program will provide outreach to Native American youth by inviting their participation in traditional talking circles (selective) and involving them in prevention activities. In addition, outreach to Native American families to participate in monthly traditional gatherings designed to spread cultural knowledge and family preservation (universal) will be conducted. Finally, during school hours, a phone line will provide access to an Native American mental health specialist who will be available via answering service to respond to school sites in situations where Native American students are experiencing a mental health crisis (indicated).

Intended Outcomes
This program is designed to –

- Improve the overall mental health care of Native American individuals, families, and communities;
- Reduce the prevalence and incidence of alcoholism and other drug dependencies;
- Maximize positive behavioral health and resiliency in Native American individuals and families thereby reducing the suicide risk, prolonged suffering, unemployment, and incarceration.
- Reduce school drop out rates.

This program will incorporate cultural, traditional and spiritual prevention interventions that have been proven effective in many Native American communities throughout tribal Nations in the United States. Continuous needs assessment and client surveys will be used to evaluate effectiveness. Evaluation will be ongoing throughout the program. NARC will conduct reviews of service documentation,

participant data, and survey results. The results and efficacy of the program will be shared with all participating agencies, including the MHD.

Comments:
PEI Program 6. How many meals expected to be delivered?

Response:
The current Area Plan (2009-2012) for the El Dorado County Area Agency on Aging reports that 385 people are served daily with 800 unduplicated participants annually in the Meals on Wheels program. Human Services also provides meals to seniors at seven dining facilities in the County. No meals are being paid for with MHSA funds. This MHSA program will provide outreach to seniors who are identified as experiencing mental distress as a result of identification by the meal delivery volunteers. In addition, an expansion of this program to include the target population of vulnerable adults will allow similar outreach, engagement and partnership with volunteers to adults who are isolated but may not be over the age of 60. The proposed program expansion is in response to community feedback regarding vulnerable adults who may not qualify for specialty mental health services and/or who may not be accessing mental health services but who are experiencing the risk factors associated with suicide, depression and isolation, limited social supports, and exposure to trauma.

Comments:
PEI Program 7. We request a detailed breakdown for "personnel expenditures" and "additional operating expenditures." Define operationally the outcomes Sandra Dunn and Associates contract to deliver for $31,744. Level of effort does not tell us what we should know. What exactly would Community Health Clinic do for the contracted funds? Is there to be a new FQHC? What is the group of private physicians? What was the initial cost of iREACH and what is the ongoing cost? Is this system not already in full implementation? Who are the anticipated "health care partners?"

Response:
To provide a better context for the responses to these questions, the following is a more detailed description of the Care Pathways model that is being applied in this PEI program. (After this description, each of the above questions is repeated and then answered.)

Care Pathways are a jointly developed series of shared, coordinated, and standardized steps/processes which are used by community health partners to bring about solutions to identified health challenges. The Care Pathways developed to-date among health partners in El Dorado County are based upon the successful outcome-based model initially developed in Ohio. Care Pathways currently in use within our County focus on helping individuals to: secure health insurance coverage; secure a medical home; use a medical home appropriately; access pediatric mental health services; and gain access to specialty care services. None of these existing Pathways were developed using MHSA funds. These cross-agency Pathways include step-by-step actions for obtaining the identified objective, resolving problems/barriers, and tracking outcomes.

Through this PEI plan, we are proposing to work collaboratively with the El Dorado County Community Health Center (a local FQHC), and other experienced resources, to develop and implement new Care Pathways specifically designed to improve health access and outcomes for adult clients with mental health needs. The proposed Pathways do not currently exist; however, once developed and implemented, will be available for use with multiple community health partners throughout our County. Specifically, we intend to develop a Pathway to ensure an effective two-way

referral process relative to mental health services (for primary care clients that may need referral to County Mental Health's high level of specialty mental health services, or for stabilized County Mental Health clients that become appropriate for referral to primary care for their psychiatric medication management, along with a lower level of behavioral health services available at a primary care setting such as a community health center/clinic). We also intend to develop a Pathway to ensure that clients who are appropriately receiving specialty mental health services from County Mental Health, are also referred to and properly using a primary care medical home to address other health issues. Ultimately, we'd like to develop additional Care Pathways/processes for improved integration of Mental Health, primary care, and alcohol/drug services.

PEI funding is proposed to be used to leverage existing resources and expertise. To support the development of new Pathways described above, we intend to procure support from individuals with prior experience in developing, implementing, and using Care Pathways in El Dorado County. We also propose obtaining evaluation support services from the Sphere Institute, or a similar firm specializing in outcome evaluation. The following summarizes the proposed experienced technical support and associated supplies:

Care Pathways/QA Manager (0.4 FTE)	$19,244	(Part-time staff in County Public Health)
Physician Champion (60 hours)	$6,000	(Such as, Jon Lehrman, M.D.)
Supplies	$1,500	
Evaluation Services	$5,000	(Such as, the SPHERE Institute)
Total	$31,744	

To support new Care Pathway design and implementation, we also propose funding staff within County Mental, as well as six months of dedicated staff (we anticipate a Clinical Social Worker, at approx. $48K) within the El Dorado County Community Health Center. We are referring to these cross-agency staff as Community Navigators since, during Pathway implementation/use, they will help individuals navigate the Care Pathways medical systems/processes and will ensure that any problems/barriers to accessing appropriate services are resolved. They will also actively work with clients to promote related self-care behaviors and assist in identifying and obtaining other natural supports that may be available within our communities to promote client wellness and recovery.

Program 7. We request a detailed breakdown for "personnel expenditures" and "additional operating expenditures."
Personnel and operating expenditures are itemized in some detail within the Budget Narrative section of Exhibit F, Program 7. Those details are included here, with additional comment included for clarification:

1. To continue services originally included as part of the Latino Engagement Initiative:
   - Personnel costs (salary and benefits) for a 0.1 FTE for a County Liaison /Utilization Review Coordinator: $12,772 [This is an EDC MHD employee who spends time providing oversight of the Latino Engagement Program.]
   - Subcontracted, professional services to provide preventative mental health services to the Latino population on the West Slope (WS) of El Dorado County and in South Lake Tahoe:
     - Family Connections (WS), $114,000 [This contract pays for community-based outreach, peer education, resource guidance and support, transportation, interpretation, prevention, early intervention, and engagement services at multiple community sites, neighborhoods and in homes to Latino adults, children and families on the Western Slope of El Dorado County.

Promotoras assist in identifying mental health needs and service options, and provide outreach to community groups; in addition, a group educator conducts on-going weekly support groups and facilitates community meetings to promote participants health, life and parenting skills, and to address the prevention of mental health issues.]

- Family Resource Center (Tahoe), $149,409 [This contract pays for Promotora services to include bilingual/bicultural Spanish-speaking outreach, engagement, screening, administration of outcome and satisfaction survey measures, service linkage, interpretation services and peer/family support to increase access and decrease health disparities. Peer and family support (individual and group) is provided for the duration of the mental health need. In addition, bilingual/bicultural Spanish-speaking early intervention counseling services may be provided for at-risk Latino individuals and their families.]

- Educational materials and supplies, $2,227
- Facility costs, indirect and overhead expenditures of $6,856. Operating expenditures include costs allocated based on the former OMB A-87 Federal Register (now Title 2, Federal Regulations (CFR), Subtitle A, Chapter ii, Part 225), including facility expenses such as rent, utilities, and janitorial services, as well as other operating expenditures such as clinical management, computing equipment and software licensing.

2. New components of this program:
   - Primary Health Systems Linkage component, totaling $89,319. [These are EDC MHD employees who will be involved in the development and implementation of the Care Pathways to increase access and linkage for adults with behavioral healthcare and primary healthcare needs. Their roles will include working with clients to ascertain primary health care needs; interfacing with physicians to aid clients in finding a medical home; assessing and evaluating clients referred from health care partners for mental health needs; and providing administrative support and follow-up services.] By job category, anticipated personnel costs are comprised of the following:
     - Psych Tech, 20 hours/week for 25 weeks (approximately 500 hours or 0.25 FTE)
     - Pathways/QA Manager, 16 hours/week for 25 weeks (approximately 400 hour or 0.2 FTE)
     - Community-based Mental Health Clinician, 40 hours a week for 25 weeks (approximately 1,000 hours or 0.5 FTE)
     - 4 hours/week for 25 weeks (approximately 100 hours or 0.05 FTE) County Liaison/Utilization Review Coordinator
     - Medical Office Assistant 8 hours/week for 25 weeks (approximately 200 hours or 0.1 FTE)
     - Mental Health Program Coordinator at 4 hours/week for 25 weeks (approximately 100 hours or 0.05 FTE)
   - Additional operating expenditures in the amount of $62,675. Once again, operating expenditures include supplies, facility expenses such as rent, utilities, and janitorial services, as well as other operating expenditures such as clinical management, computing equipment and software licensing. These costs are allocated based on the former OMB A-87 Federal Register (now Title 2, Federal Regulations (CFR), Subtitle A, Chapter ii, Part 225).
   - Professional services to develop and implement cross-agency outcomes-based Care Pathways and to mobilize movement toward linkage, collaboration and integration of physical and mental health services as described above:
     - Care Pathways Physician Champion (MD in role of Liaison/Advocate), $6,000
     - Program Evaluation Services for Care Pathways program, $5,000
     - Community Health Center, $48,000 [This will be used to fund salary and benefits for a full-time Licensed Clinical Social Worker (for a period of six months, equivalent to 0.5 FTE) who will help to coordinate services with the El Dorado County Community Health Center to

establish and utilize care pathways. This is time-limited funding to support the active participation of the Community Health Center; during the initial six months, it is anticipated that program start-up will require a higher level of systems development and implementation work. Thereafter, the ongoing navigation will be related to supporting clients needing services.]

Define operationally the outcomes Sandra Dunn and Associates contract to deliver for $31,744. Level of effort does not tell us what we should know.

We do not anticipate contracting with Sandra Dunn and Associates – information regarding the resources anticipated to be needed to develop and implement new Care Pathways specifically addressing behavioral health and primary care integration was acquired from Sandra Dunn as her agency had previously participated in development/implementation of other Care Pathways already being effectively utilized within the County.

As noted above, the PEI plan funds the development and implementation of care pathways for adults with mental health needs, including two-way referral pathways between County Mental Health and other community primary care partners. We anticipate that the broad outcomes will include the development of electronic care pathways support within iREACH to most efficiently facilitate the primary care and mental health care needs of adults. More specific contract negotiations are dependent on approval of the PEI funding request.

What exactly would Community Health Clinic do for the contracted funds?

As noted above, funding for the Community Health Center would support the hiring of a full-time Licensed Clinical Social Worker for a period of six months to participate with the MHD in development and implementation of care pathways in order to better coordinate primary care and mental health care services. This individual will help clients navigate the care pathways medical systems/processes and will ensure that any problems/barriers to accessing services are resolved. She/he will also work with clients to promote related self-care behaviors and will assist in identifying and obtaining other natural supports that may be available within communities to promote client wellness and recovery.

Is there to be a new FQHC?

This program does not fund the development of a new FQHC nor are we aware of any other project currently proposed or under discussion that would fund the development of a new FQHC. This program proposes working with an existing FQHC, the El Dorado County Community Health Center, in the development of Care Pathways to improve care for clients with mental illness.

What is the group of private physicians?

The private physicians involved in the Access El Dorado (ACCEL) Initiative are primarily associated with the agencies involved as community health care partners the ACCEL-Initiative's Care Pathways program. These are Barton Healthcare System, Marshall Medical Center, El Dorado County Community Health Center, and Shingle Springs Tribal Community Health Clinic. Existing Care Pathways involve participants from many disciplines: physicians, nurses, community health workers, mental health clinicians, and administrators.

COMMUNITY PROGRAM PLANNING
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What was the initial cost of iREACH and what is the ongoing cost? Is this system not already in full implementation?

Initial funding for the ACCEL Initiative came when the El Dorado County Board of Supervisors allocated Tobacco Master Settlement Funds to address health care needs in the County. A variety of grants also supported ACCEL activities, including the Care Pathways developed to date. iREACH is the web-based health information management system that is used by the ACCEL community health partners; this technological tool is in place and will not be funded by MHSA. We do not have information on the initial and on-going cost of iREACH; most recently, funding and technical support for iREACH has been provided by two local, private hospitals.

However, in order for iREACH to be used to address the specific service needs of mental health clients, new pathways must be analyzed, mapped and programmed. To date, ACCEL has developed six care pathways to improve access to medical care and these are fully operational. This PEI plan funds the development and implementation of new care pathways specifically for adults with mental health needs. Currently these pathways do not exist. The funding requested for a Pathways/QA Manager (16 hours/week for 25 weeks) will be used to support this function. The plan is to use an existing tool (iREACH) and leverage existing collaborative resources and expertise to better coordinate health care services for adult mental health clients.

Who are the anticipated "health care partners?"
Community health care partners participating in the Access El Dorado (ACCEL) Initiative's Care Pathways program along with the County Health Services Department are: Barton Healthcare System (with affiliated medical providers and rural clinic), Marshall Medical Center (with affiliated medical providers and rural clinic), El Dorado County Community Health Center, and Shingle Springs Tribal Community Health Clinic.

Comment:
Across all Programs, what is the anticipated total funding for Community Health Center in the EDC MHD budget?

Response:
PEI Plan 7 Health Disparities (proposed) $48,000.

Comment:
What are the MHSA proposed or existing contracts, amounts, and provider locations proposed under this plan? Please provide a table with this information – including a brief description of each contract.

COMMUNITY PROGRAM PLANNING
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Response:

Vendor	**Program: PEI**	**Amount**
Black Oak Mine School District 6540 Wentworth Springs Road PO Box 4510 Georgetown, CA 95634 Serving the communities of Pilot Hill, Cool, Greenwood, Georgetown, Garden Valley, Kelsey, and Volcanoville	#2 Primary Intervention Project (PIP) At two locations within the Georgetown Divide Region, teachers and a screening team will identify children "at risk" for developing emotional problems, as indicated by school adjustment difficulties. For children identified as appropriate for PIP intervention, trained PIP aids will provide program services in the form of one-on-one, non-directive play for approximately 30-45 minutes per week for 12-15 weeks.	$84,000
Vision Coalition: El Dorado Hills Community Vision 895 Embarcadero Drive #208 El Dorado Hills, CA 95762	#2 Primary Intervention Project (PIP). Vision Coalition will provide PIP services equivalent to those described in the Black Oak Mine School District contract at one location in El Dorado Hills. (Oak Meadow Elementary School).	$42,000
	#3 Incredible Years (IY) Vision Coalition will furnish personnel, materials and facilities necessary for County Mental Health staff to conduct IY Workshops in El Dorado Hills. Specifically, Vision Coalition will coordinate program advertisement and referrals, provide adequate facilities and custodial services, and provide the necessary materials and staffing for childcare activities while parents attend IY classes.	$10,000
Total VC Contracts Amount		$52,000
South Lake Tahoe Tot Spot Tahoe Tot Spot 1012 Al Tahoe Blvd South Lake Tahoe, CA 96150	#3 Incredible Years (IY) Use of the Tot Spot facility necessary for County Mental Health staff to conduct IY Workshops in South Lake Tahoe. This will include site supervision and the cost to provide an additional Child Care Worker.	$1,500

COMMUNITY PROGRAM PLANNING
AND LOCAL REVIEW PROCESS

Vendor	**Program: PEI**	**Amount**
MHD partners with NAMI to have staff trained as trainers in NAMI modalities – no contract	#4 Community Education Project support Family to Family Training	$2,000
CiMH California Institute for Mental Health (CiMH) 2125 19th Street, 2nd Floor Sacramento, CA 95818	#4 Community Education Project-Provide Training to Mental Health Commission	$1,200
MHD purchases materials for distribution by PFLAG volunteers – no contract	#4 Conduct Education Project-materials, support Outreach, Education and Training Activities	$2,000
Foothill Indian Education Alliance 100 Forni Road Placerville, CA 95667 Mail to: P.O. Box 1418 El Dorado, CA 95623	#5 Wennam Wadati: This program will center on traditional talking circles, monthly family gatherings and crisis intervention for youth and families in El Dorado County. Specific services will include the implementation of school-based Talking Circles, Native American cultural activities, oversight of a dedicated telephone crisis line, and the provision of monthly student leadership youth activities, including suicide prevention strategies, mental and spiritual health issues, issues related to family dynamics, peer pressure, dating, mental health and wellness.	$116,865
Family Connections 344 Placerville Drive Suite 10 Placerville, CA 95667	#7 Health Disparities Provide Preventative Mental Health Services West Slope targeting the Latino population	$114,000
Family Resource Center 3501 Spruce Avenue, Suite B South Lake Tahoe, CA 96150	#7 Health Disparities Provide Preventative Mental Health Services South Lake Tahoe targeting the Latino population.	$149,409

COMMUNITY PROGRAM PLANNING
AND LOCAL REVIEW PROCESS

Vendor	**Program: PEI**	**Amount**
Community Health Center El Dorado County Community Health Center 4327 Golden Center Dr Placerville, CA 95667	#7 Health Disparities: specifically to ensure smooth transitions for clients who are referred for mental health services by primary care or need to be seen by a primary care provider – develop and implement cross agency outcomes-based Care Pathways and to mobilize movement towards linkage, collaboration and integration of physical and mental health care.	$48,000
Public Health Division costs – Care Pathways Manager and Supplies El Dorado County Health Services Public Health Division 931 Spring Street Placerville, CA 95667	#7 Health Disparities: specifically to ensure smooth transitions for clients who are referred for mental health services by primary care or need to be seen by a primary care provider – develop and implement cross agency outcomes-based Care Pathways and to mobilize movement towards linkage, collaboration and integration of physical and mental health care.	$20,744
Dr Jon Lehrman – Physician Champion Family Practice Marshall Center Provider 1095 Marshall Way Placerville, CA 95667	#7 Health Disparities: specifically to ensure smooth transitions for clients who are referred for mental health services by primary care or need to be seen by a primary care provider –develop and implement cross agency outcomes-based Care Pathways and to mobilize movement towards linkage, collaboration and integration of physical and mental health care.	$6,000
SPHERE – evaluation component The SPHERE Institute 500 Airport Blvd. Suite 340 Burlingame, CA 94010	#7 Health Disparities: specifically to ensure smooth transitions for clients who are referred for mental health services by primary care or need to be seen by a primary care provider – develop and implement cross agency outcomes-based Care Pathways and to mobilize movement towards linkage,	$5,000

	collaboration and integration of physical and mental health care.	
Vendor	**Program: CSS**	**Amount**
Crossroads Diversified 9300 Tech Center Drive #100 Sacramento, CA 95826	#2: Adult Wellness and Recovery Services. Crossroads will provide vocational rehabilitation and related skills training to severely mentally ill adults. Specific services consist of vocational assessment, pre-employment classes, individual support services to aid clients in finding employment, employment preparation classes, job development and placement services, post-employment support, small business development, and additional support services as needed.	$99,800
Trails Trails at the Lake 2572 Lake Tahoe Blvd. #2 South Lake Tahoe, CA 96150	#2: Adult Wellness and Recovery Services. Trails will provide services necessary to enable clients referred by the County to engage in work readiness activities including competitive employment. Specific services include vocational assessment, pre-employment classes, job development and placement services and other employment-related services similar to those described in the Crossroads Diversified contract.	$30,000
Turning Point Turning Point Community Programs (TPCP) 3440 Viking Drive, Suite 114 Sacramento, CA 95827	#2: Adult Wellness and Recovery Services. Turning Point serves as a consultant and expert in the provision of Full Service Partnership (FSP) training, assessment and planning to ensure quality of services and MHSA program compliance. Services will consist of Recovery-Oriented Immersion training for staff and community partners; coordination of informant interviews, focus groups and partnership meetings to address	$58,000

	community mental health and FSP issues; focused client assessment to ensure that the appropriate clients are served by this model; and specialized FSP treatment planning.	

August 25, 2010 – additional questions were posed verbally in a joint Mental Health Commission meeting. The following is a list of the questions and the MHD responses:

Feedback:
It is difficult to determine from the MHSA Plan draft what the contractors are expected to deliver in regard to measurable outcomes.

Response:
The DMH-required MHSA plan application form and structure dictates what information is requested and therefore provided by counties. The information requested ensures compliance with the MHSA requirements. The County later develops contracts when community providers are used to deliver MHSA services; these contracts articulate the scope of work, reporting requirements, and deliverables, and other performance measures. The contracts also specify the compensation terms and include many other contract provisions.

Question:
How much leeway is built into the MHSA plan application? In other words, the Mental Health Commission needs to know how much detail realistically should be expected in the Plan?

Response:
The State DMH actually publishes a document that shows how they review the Plan Updates and this document is available on their website and can be shared with the Mental Health Commission at the next meeting.

Question:
What are the services and programs proposed under the CSS program? Why is there so little information about this program?

Response:
The CSS program update pages are more limited in number than those under WET and PEI largely because in following the DMH application structure, limited information was requested since these programs are not being changed.

Under CSS there are now two programs:

- The Family and Youth Strengthening Program includes Wraparound Full Service Partnerships, use of evidence-based practices, and a Transitions Program for youth in detention
- The Adult Wellness and Recovery Services Program includes Assertive Community Treatment (ACT) Full Service Partnerships, a Wellness Center program offering groups and a clubhouse, as well as case management and counseling services

Contracted services include vocational rehabilitation and a proposed new contract with Turning Point

to provide a Full Service Partnership program assessment.

Feedback:
The Commission would like to know what agencies are receiving MHSA funding, the amounts, and what the contracts are for.

Response:
A table of the contract providers and contract amounts was provided to one of the subcommittee members – however, this did not include the CSS contracts mentioned above. We will amend the list to include the CSS information.

Question:
Why are MHSA funds being used to pay for a new FQHC?

Response:
The statement about developing a new FQHC on the PEI Program #7, Health Disparities, Exhibit F4 was provided as background information in relationship to an existing program – ACCEL in which a FQHC was established in El Dorado County with Tobacco Settlement funding through the efforts of the Public Health Department in 2002. There is no plan to use MHSA funds to create another FQHC in El Dorado County.

MHSA funds are being proposed to build on this project by use of the successful Care Pathways model to better coordinate referrals and linkage to services for adults with serious mental illness. Some adults may first approach the MHD for mental health services but are more appropriate for services provided at the FQHC. Conversely, some adults may approach the FQHC but require specialty mental health services, such as those provided by the MHD. Finally, some clients appropriately served at the MHD may need a primary healthcare home and doctor, and the FQHC may be the appropriate provider for those services. Each of these instances can benefit from having a clearly defined and agreed upon pathway or referral system by which clients can be effectively linked to the appropriate level and type of services to best meet their needs.

Question:
Why are the Latino and Native American programs being eliminated?

Response:
The Exhibit D1 was completed, as required, for the CSS program. This form was used to indicate that, as approved in the last plan update, the Health Disparities programs were moved from the CSS program to the PEI program in January 2010. As a result, the contracted services formerly funded by MHSA CSS funds were transferred to be funded by MHSA PEI funds, and the Health Disparities program was “eliminated” from the CSS program. Contracted services to the Latino population in SLT and the WS are continuing uninterrupted and services to the Native American population will be funded under PEI Program #5.

Question:
Doesn’t the Vision Coalition and the Community Health Center have other grant funds and/or funding sources?

Response:
We believe these agencies may have other grant funding but this would need to be confirmed with them. In regard to the proposed MHSA funding for these agencies, it is important to keep in mind that grant funds are typically earmarked for specific projects. For example, the MHSA funds proposed for the specific MHSA projects in this Plan Update cannot be used for other operational needs at the Vision Coalition or Community Health Center. It is our understanding that MHSA funds are needed for these agency projects because they do not have alternative funding sources that can pay for these MHSA-proposed projects.

September 2, 2010 – Recommendations were formally approved for submission by the Mental Health Commission to the MHD in relationship to the FY 10/11 MHSA Plan Update. The following is a list of the recommendations and the MHD responses:

Feedback:
The majority of the Commission members felt that they did not have enough information about the MHSA plan.

Response:
The MHD recognizes that this document contains a large amount of information and can be difficult to read. It was clarified that the document is comprised of the State-required forms necessary to acquire the MHSA funding. In addition, the MHD has recently experienced significant and fast-paced change at the programmatic, fiscal and administrative levels in order to address recent serious fiscal challenges. As a result, time will be required to work together to share information and provide the necessary training so that the Commission feels better informed. The MHD is committed to working in partnership with the Commission to this end.

Feedback:
Based on the findings in the Commission's report to the Board of Supervisors in March 2010, we [the Commission] recommend that the Mental Health Division develop an alternate means of providing psychiatric rehabilitation services, other than using the Life Skills Modules published by Robert Liberman, et al, from work done at the Veterans Hospital-Brentwood. We advise that the Division redirect the $31,000 identified for training staff on evaluations of the Liberman materials. The Commission has already evaluated the way those materials have been used, via consumer interviews, and has found sufficient dissatisfaction to warrant a new approach. The funding should instead go towards purchasing a set of materials developed by the Center for Psychiatric Rehabilitation, affiliated with Boston University, and evaluating their approach. In the first year, this funding may go also towards staff training in the use of these materials. We request that the staff develop a plan to phase out the Life Skills Modules, while implementing the Boston University approach. We realize that this will take several months to accomplish. Consumers who seem to be receiving some benefit from the Modules considered appropriate for them would complete them through the end of the respective workbooks as the new program is phased in. The Consumer Leadership Committee would be a good choice to look over possible new programs.

Response:
The MHD has taken note of the feedback from 14 South Lake Tahoe consumers regarding the skills training classes. Since March, alternative group models have been investigated. As a result, both WS and SLT staff have been trained in an anger management group module and materials for

another group model addressing trauma and addictions has been purchased – training will be pursued, as well. The MHD is very interested in learning about the Boston University approach and has requested information from a graduate of this program. In addition, other models will be explored. At this time, there is not a specific plan to phase out the skills training classes – a key strategy is to ensure that there are treatment options and consumer choice. However, the MHD is committed to investigating and considering other approaches, such as that of Boston University.

Feedback:
The Commission would like to have provisions made for ways to enrich the lives of consumers who live in Board and Care facilities and for those who have living arraignments that are not ideal. The above mentioned consumers should have more enriching experiences outside in the real world. The Commission would like to see where in the MHSA plan are there provisions for the enrichment of consumer residents in Board and Care and what the exact allocation is.

Response:
On the second page of Exhibit D, under the Wellness Center and Clubhouse, the following statement is included:

"Community reintegration activities and life skills training will be provided for Crisis Residential Treatment Facility clients and others deemed appropriate. The target population includes clients who reside in Board and Care Homes."

It is under this CSS Plan #2, funded at $2,753,432/year that MHSA funds may be applied for enrichment activities for clients who reside in Board and Cares.

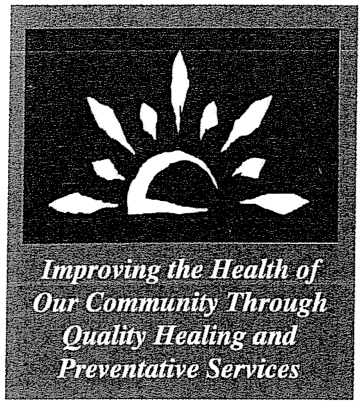
September 2, 2010 - Recommendations were presented verbally by the Consumer Leadership subcommittee of the Mental Health Commission to the MHD in relationship to the FY 10/11 MHSA Plan Update. The following is a list of the recommendations and the MHD responses:

Feedback:
The Consumer Leadership Subcommittee of the MH Commission recommended combining the budget line items for stipends ($5,000) and training ($10,000) for the Leadership Academy for increased flexibility in the use of these dollars. They further requested clarification regarding the distinction between strategies to address consumers and strategies to address family members under the MHSA PEI Community Education Program #4. In addition, they recommended that staff resources to support the Leadership Academy are extra help mental health aide positions filled with consumers.

Response:
The budget has been adjusted as suggested for increased flexibility. The language in the plan has been amended to clarify that there was an intended distinction between activities for the Consumer Leadership Academy (transportation assistance, funding for stipends and training) versus activities in support of the Mental Health Commission training ($1,200). The language in the plan has been amended to clarify that the role of the Patient Rights Advocate and the WET Coordinator is targeting the WET - funded Volunteer Program - we do anticipate that both consumers and family members will continue to serve as volunteers and thereby will benefit from this program. Extra help mental health aides will be available to assist and participate in the quarterly county-wide gatherings of the Leadership Academy.

COMMUNITY PROGRAM PLANNING AND LOCAL REVIEW PROCESS

September 1, 2010 - Letter in support of the plan from James Ellsworth, Executive Director, Community Health Center.



El Dorado County
Community Health Center

4327 Golden Center Drive
Placerville, CA 95667
(530) 621-7700 Fax (530) 621-7707

4641 Missouri Flat Road
Placerville, CA 95667
(530) 621-7700 Fax (530) 622-8436

September 1, 2010

MHSA Project Management
El Dorado County Health Services Department, Mental Health Division
670 Placerville Drive, Suite 1B
Placerville CA 95667
Attention: Stephanie Carlson

Gentlepersons:

This letter will serve to communicate our support for the proposed programs and budgets set forth in the Mental Health Services Act FY2010-11 Plan for El Dorado County. We look forward to collaborating with the Mental Health Division of El Dorado County in delivering behavioral health services.

Sincerely,

James Wm. Ellsworth
Executive Director

2010/11 ANNUAL UPDATE **EXHIBIT C1**

IMPLEMENTATION PROGRESS REPORT ON FY 08/09 ACTIVITIES

County: El Dorado

Date: September 28, 2010

Instructions: Welfare and Institutions Code section 5848 specifies that DMH shall establish requirements for the content of the annual update and updates including reports on the achievement of performance outcomes for services. Provide an update on the overall progress of the County's implementation of the MHSA including CSS, PEI and WET components during FY 2008/09.

CSS, WET and PEI

1. Briefly report on how the implementation of the MHSA is progressing: whether implementation activities are generally proceeding as described in the County's approved Plan, any key differences, and any major challenges.
[X] Please check box if PEI component not implemented in FY 08/09.

MHSA CSS Workplan #1 – Youth and Family Strengthening Program Progress

Use of Assessment Tools
During this fiscal year, staff training in the use of the CALOCUS (Child and Adolescent Levels of Care Utilization System) rather than the Child and Adolescent Service Intensity Instrument (CASII) took place. As expected, a baseline measure of all youth served by both the Mental Health Division (MHD) staff and the local outpatient services contract providers (New Morning, Summitview, and Sierra Family Services) took place. The findings were applied to match the level of service delivery to the assessment findings. Discussions regarding continuous use of the tool have taken place since that time. The Adult Services Team and the South Lake Tahoe Team are moving forward to implementation of routine use of the CALOCUS and LOCUS, and the WS Children's Services Team is evaluating ongoing application of the CALOCUS in the EPSDT Planning Group. This application is considered a major challenge by the Team.

Wraparound FSP
As planned, the desire to most effectively use MHSA funds – including in the application of FSP programs – resulted in a broadening of the target population for this strategy (inclusion of Medi-Cal eligible youth) in order to leverage funds. In keeping with the goal of preventing out-of-home placement, this shift also included an emphasis on youth grades K-6 who were not eligible for the SB163-funded Wraparound program. The program was able to continue to serve a few uninsured youth, as anticipated. The current challenge in FY 10-11 is a result of the inability of the County General Fund to provide the necessary match to draw down SB163 funds. As a result, the ability to leverage Wraparound personnel resources (Parent Partner, Wrap Workers) will be limited. The MHD and the County Human Services Department continues to partner to serve high-risk youth to minimize out-of-home placements by use of this model. MHSA funding to this end is increasingly valuable.

Family Strengthening Academy
Consistent with the Workplan, a variety of evidence-based practice strategies were employed to serve the County's youth (e.g., Incredible Years, Teaching Pro-social Skills or TPS, and Trauma-focused Cognitive Behavioral Therapy). As a result, use of group intervention strategies began to increase. However, the data indicates that we did not serve the anticipated number of youth and families in this program. Further, we did not gather data to annotate the number of non-Medi-Cal youth or uninsured youth served. In a recent External Quality Review Organization (EQRO) site visit, it was determined that the opportunities for outcome and fidelity measures had not been consistently applied. Therefore, a future challenge will be to establish and maintain improved data collection methodologies.

Transitions Project
As planned, the MHD has provided MHSA-funded staff and services to youth and families involved with the juvenile justice system. TPS groups, family re-unification services, and discharge planning service linkage have been provided on both slopes. These services are extremely well-received and viewed as invaluable to this high-risk population. Future challenges include the limited capacity available based the MHD staffing levels and limits of the MHSA CSS funding.

IMPLEMENTATION PROGRESS REPORT ON FY 08/09 ACTIVITIES

MHSA CSS Workplan #2 – Wellness and Recovery Services Program

Consistent with the plan, the MHSA adult programs were integrated and streamlined along levels of care dimensions. Use of the LOCUS was applied to all adult clients to establish a baseline measure by which to align service plans with level of need. In addition, the populations served through this wellness and recovery-oriented approach were more broadly defined to include those at risk of homelessness, institutionalization, and those living in the community at all levels (board and care, transitional housing, independent living, etc.). The goals of reducing recidivism to institutions, such as the jails, Institutes of Mental Disease (IMDs), and hospitals were incorporated, as well.

Staff training in the Social and Independent Living Skills (SILS) evidence-based practice was conducted and multiple groups were started in various settings. Case management was added for clients who preferred to receive medication services only, and Assertive Community Treatment (ACT) was used as a service intervention strategy for various clients who posed high-risk and/or who were at imminent risk of institutionalization, as with many of our Transitional Age Youth (TAY) and Transitional Housing clients.

Areas of key differences included a decrease in our capacity to serve clients in an ongoing outreach and engagement modality, the discontinuation of the CMSP grant participation and our on-site presence at a local primary care setting, and inability to staff a data management and program evaluation unit. Hence, future challenges include establishing the mechanism and resources to provide outreach and engagement, to partner with primary healthcare, and to conduct the program evaluation necessary for compliance and quality assurance purposes.

MHSA CSS Workplan #3 – Crisis Residential Facility

The Crisis Residential Facility was renamed as the Crisis Residential Treatment (CRT) Facility and opened in early February. It has quickly become a successful and valued program, assisting clients who are transitioning out of the Psychiatric Health Facility (PHF) and clients served in the community who require brief, crisis stabilization in a 24-hour supervised setting. Staff, community members, and clients have provided unsolicited positive feedback regarding both the value of this additional level of care and the welcoming setting in which the care is provided.

A challenge is the limit of space and capacity – today, the 6 beds are often full.

MHSA CSS Workplan #4 – Health Disparities and Culturally-specific services

This initiative has continued through the provision of services by community contract providers. Addressing levels of care planning did not take place, as originally intended. However, the Latino providers reported active use of outreach, engagement and group services.

One of the ongoing challenges remains the integration of service delivery between the providers and the MHD. Improved collaboration allows the system to better serve the clients and community as a whole in an increasingly culturally competent way. Strategies by which to improve the various partnerships include training and cross-training opportunities, clarification of expectations through the contracts planning process, regularly scheduled contracts review and service provider meetings, and improved data collection and reporting tools. Resources for these processes must, therefore, be identified.

MHSA WET Program – as expected, key differences, and major challenges

This plan was approved mid fiscal year. During this fiscal year, a Reduction in Force (RIF) resulted in a 29% decrease in permanent staff allocations and many extra help positions, as well. However, the findings of the workforce assessment needs remain relevant. Challenges continue in the area of psychiatrist recruitment and sufficient on-site Spanish language capacity. In addition, while MHSA funding and programming has resulted in some progress, the meaningful participation of consumer and family members remains an important growth area. One area where progress has been made – the use of registered and licensed clinicians for the assessment of clients is now universal.

During this year of significant transition, upon plan approval a full-time Workforce Education and Training (WET) Coordinator was assigned. Research regarding the e-learning technology options, the establishment of the Social and Independent Living Skills (SILS) training modules and the related partnership with the High School Health and Human Services Academy, negotiations regarding participation in the Rural Mental Health MSW Weekend Program, and the transition of the Friendly Visitor Program to the WET Consumer and Family Volunteer Program were among the activities staffed by the WET Coordinator and the MHSA Project Management Team.
A highlight of the year included the series of SILS training classes that were attended by MHD staff, consumers, family members and high school students and teachers. At this time, we do have SILS classes being co-facilitated by staff and consumers, as well.

IMPLEMENTATION PROGRESS REPORT ON FY 08/09 ACTIVITIES

Challenges included the inability to sustain a full time assignment to the WET Coordinator position due to Division capacity limits and to sustain a Clinical Outcomes Measures program specific to the Behavioral Health Court. In addition, the interface of the MHD's SILS training initiative with the High School Academy was challenging in part due to the different goals that the two agencies are tasked with addressing. Finally, one of the unfunded activities – the coordination of interagency internships and clinical supervision – was beyond the capacity scope of this new program with extremely limited funding and capacity.

We also discovered new information along the way that informed the implementation of the WET Plan. This proposal includes a recommendation for a decrease in the funding for the administrative costs of the MHSA Rural Mental Health Weekend Program due to the decreased local county participation. Further, that we eliminate the funding for a local Loan Assumption program as we learned that there are several programs for which the El Dorado County public mental health workforce may be eligible given the County designation as a Health Professional Shortage Area (HPSA) in January 2008. These key differences will be addressed in the proposed WET plan update.

2. Provide a brief narrative description of progress in providing services to unserved and underserved populations, with emphasis on reducing racial/ethnic service disparities.

Racial and Ethnic Group Service Disparities Highlights

- Of the youth served in the Wraparound program, 43% were Latino.
- 42% of the MHSA clients served were non-Caucasian (compared to 9% of the overall County population).
- 22% of the MHSA clients served were primary language, Spanish-speaking (compared to 10% of the County population for whom the language spoken at home is other than English)
- The Health Disparities Programs served 28% of the total numbers of clients served.

The MHSA emphasis on reducing racial/ethnic services disparities was supported by the County MHSA programs during FY 08-09.

Please note that El Dorado County has one threshold language – which is Spanish.

3. Provide the following information on the number of individuals served:

	CSS	PEI	WET	
Age Group	**# of individuals**	**# of individuals (for universal prevention, use estimated #)**	**Funding Category**	**# of individuals**
Child and Youth (0-17)	**52**		Workforce Staff Support	
Transition Age Youth (16-25)	**72**		Training/Technical Assist.	**108**
Adult (18-59)	**548**		MH Career Pathway	**77**
Older Adult (60+)	**80**		Residency & Internship	**0**
Race/Ethnicity		**CSS Rates**	Financial Incentive	**3**
White	**399**	**57%**		
African American	**7**	**1%**	[ ] WET not implemented in FY 08/09	
Asian	**6**	**0.9%**		
Pacific Islander	**6**	**0.9%**		
Native American	**88**	**13%**		
Hispanic	**188**	**27%**		
Multi				
Other				
Unknown	**2**	**0.3%**		
Other Cultural Groups				
LGBTQ	**unknown**			
Other				
Primary Language		**CSS Rates**		
English	**539**	**77%**		
Spanish	**155**	**22%**		
Vietnamese				
Cantonese				
Mandarin				
Tagalog	**1**	**0.1%**		

IMPLEMENTATION PROGRESS REPORT
ON FY 08/09 ACTIVITIES

Cambodian		
Hmong		
Russian	1	0.1%
Farsi		
Arabic		
Other		

PEI

4. Please provide the following information for each PEI Project in short narrative fashion:
- **a) The problems and needs addressed by the Project.**
- **b) The type of services provided.**
- **c) Any outcomes data, if available. (Optional)**
- **d) The type and dollar amount of leveraged resources and/ or in-kind contributions (if applicable).**

NA – no PEI program implementation in FY 08-09.

2010/11 ANNUAL UPDATE

EXHIBIT E

MHSA SUMMARY FUNDING REQUEST

County: El Dorado

Date: 9/28/2010

	MHSA Funding					
	CSS	**WET**	**CFTN**	**PEI**	**INN**	**Local Prudent Reserve**
A. FY 2010/11 Planning Estimates						
1. Published Planning Estimate	$3,260,500			$798,000	$485,500	
2. Transfers	$0	$0	$0			
3. Adjusted Planning Estimates	$3,260,500					
B. FY 2010/11 Funding Request						
1. Requested Funding in FY 2010/11	$4,588,048	$363,682	$0	$2,018,644	$0	
2. Requested Funding for CPP	$0			$0	$0	
3. Net Available Unexpended Funds						
a. Unexpended FY 06/07 Funds		$277,134				
b. Unexpended FY 2007/08 Funds[a/]	$0	$0	$0			
c. Unexpended FY 2008/09 Funds	$1,327,548		$0	$75,929		
d. Adjustment for FY 2009/2010		$277,134		$75,929		
e. Total Net Available Unexpended Funds	$1,327,548	$0	$0	$0	$0	
4. Total FY 2010/11 Funding Request	**$3,260,500**	**$363,682**	**$0**	**$2,018,644**	**$0**	

2010/11 ANNUAL UPDATE

EXHIBIT E

MHSA SUMMARY FUNDING REQUEST

C. Funds Requested for FY 2010/11						
1. Previously Approved Programs/Projects						
a. Unapproved FY 06/07 Planning Estimates		**$0**				
b. Unapproved FY 07/08 Planning Estimates[a/]	$0	$0				
c. Unapproved FY 08/09 Planning Estimates	**$0**		Pending resolution of inquiry submitted to DMH	**$257,204**		
d. Unapproved FY 09/10 Planning Estimates	**$0**			**$295,137**		
e. Unapproved FY10/11 Planning Estimates	**$3,260,500**					
Sub-total	**$3,260,500**	**$0**		**$552,341**	**$0**	
f. Local Prudent Reserve	**$0**			$0		
2. New Programs/Projects						
a. Unapproved FY 06/07 Planning Estimates						
b. Unapproved FY 07/08 Planning Estimates[a/]	0	$363,682				
c. Unapproved FY 08/09 Planning Estimates	0					
d. Unapproved FY 09/10 Planning Estimates	0			$922,963		
e. Unapproved FY10/11 Planning Estimates	0			$543,340		
Sub-total	$0	$363,682	$0	$1,466,303	$0	
f. Local Prudent Reserve	0			$0		
3. FY 2010/11 Total Allocation[b/]	**$3,260,500**	**$363,682**	**$0**	**$2,018,644**	**$0**	

a/Only applies to CSS augmentation planning estimates released pursuant to DMH Info. Notice 07-21, as the FY 07/08 Planning Estimate for CSS is scheduled for reversion on June 30, 2010.

b/ Must equal line B.4. for each component.

2010/11 ANNUAL UPDATE **EXHIBIT D**

PREVIOUSLY APPROVED PROGRAM

County: El Dorado

Program Number/Name: #1 Youth and Family Strengthening Program

Date: 9/28/2010

Select one:
☑ CSS
☐ WET
☐ PEI
☐ INN

CSS and WET				
Previously Approved				
No.	**Question**	**Yes**	**No**	
1.	Is this an existing program with no changes?	☒	☐	If yes, answer question #5 and complete Exh.E1 or E2 accordingly; If no, answer question #2
2.	Is there a change in the service population to be served?	☐	☑	If yes, complete Exh. F1; If no, answer question #3
3.	Is there a change in services?	☐	☑	If yes, complete Exh. F1; If no, answer question #4
4.	Is there a change in funding amount for the existing program?	☑	☐	If yes, answer question #4(a); If no, complete Exh. E1or E2 accordingly
a)	Is the change within ±15% of previously approved amount?	☑	☐	If yes, answer question #5 and complete Exh. E1or E2; If no, complete Exh. F1 and complete table below.

FY 09/10 funding	FY 10/11 funding	Percent Change

5. **For CSS programs:** Describe the services/strategies and target population to be served. This should include information about targeted age, gender, race/ethnicity and language spoken of the population to be served.
For WET programs: Describe objectives to be achieved such as days of training, number of scholarships awarded, strategies that expand outreach, recruitment and retention efforts to increase diversity in mental health workforce and other major milestones to be reached.

The Youth and Family Strengthening Program provides at-risk and under-served youth of all ages with a range of outreach programs, treatment options and general services. Targeted at-risk youth include those who are not succeeding at school as well as those at risk of out-of-home placement and those currently or previously involved with the juvenile justice system. The identified population of under-served youth includes Latino and Native American children and adolescents, youth in grades K-6 who are at risk of out-of-home placement, and transition age youth (16-17). Families with mentally ill parents,TAY at risk of homelessness, and Native American male youth are also identified as high risk and under-served.

Services provided under the CSS Youth and Family Strengthening Program include the following:

MHSA Wraparound (Outreach and Engagement and FSP program)
Wraparound services are available for at least five full service partnerships distributed county-wide as need arises and capacity allows. These services are available to both Medi-Cal and non-Medi-Cal ("scholarship") youth and families, and the program generally but not exclusively serves youth in grades K through 6 who are at risk of out-of-home foster-care placement. Outreach and engagement services as well as other supportive activities, including but not limited to food, youth activities, and transportation, may be funded by MHSA for stabilization purposes.

Family Strengthening Academy (General Systems Development program)
The county-wide Family Strengthening Academy offers a range of promising, best, and evidence-based practices (including but not limited to the Incredible Years, Teaching Pro-Social Skills (TPS) and Trauma-Focused Cognitive Behavioral Therapy) in a variety of settings. These programs are designed to promote family unification in a cost-effective manner (Outreach and Engagement and General Systems Development funded). MHSA funds may used to provide a limited number of "scholarships" for uninsured or under-insured youth and families to participate. Food, household items, childcare and transportation to and from groups may be offered.

*PEI Projects previously approved are now called Previously Approved Programs

PREVIOUSLY APPROVED PROGRAM

Transitions Project (General Systems Development program)
At-risk youth and transition age youth receive discharge planning and family-reunification services prior to and immediately following release from the juvenile hall in both the SLT and WS regions of the County. This strategy is designed to engage youth and transition age youth and their families in mental health, addiction and other specialized treatment services in order to reduce recidivism and out-of-home placements. The Transitions Project provides support and strengthens the families of youth who are under-served and may be at-risk for further detention and/or homelessness.

*PEI Projects previously approved are now called Previously Approved Programs

2010/11 ANNUAL UPDATE **EXHIBIT D**

PREVIOUSLY APPROVED PROGRAM

County: El Dorado

Program Number/Name: #2 Adult Wellness and Recovery Services

Date: 9/28/2010

Select one:
☑ CSS
☐ WET
☐ PEI
☐ INN

CSS and WET				
Previously Approved				
No.	**Question**	**Yes**	**No**	
1.	Is this an existing program with no changes?	☒	☐	If yes, answer question #5 and complete Exh.E1 or E2 accordingly; If no, answer question #2
2.	Is there a change in the service population to be served?	☐	☑	If yes, complete Exh. F1; If no, answer question #3
3.	Is there a change in services?	☐	☑	If yes, complete Exh. F1; If no, answer question #4
4.	Is there a change in funding amount for the existing program?	☑	☐	If yes, answer question #4(a); If no, complete Exh. E1or E2 accordingly
a)	Is the change within ±15% of previously approved amount?	☑	☐	If yes, answer question #5 and complete Exh. E1or E2; If no, complete Exh. F1 and complete table below.
5.	**For CSS programs:** Describe the services/strategies and target population to be served. This should include information about targeted age, gender, race/ethnicity and language spoken of the population to be served. **For WET programs:** Describe objectives to be achieved such as days of training, number of scholarships awarded, strategies that expand outreach, recruitment and retention efforts to increase diversity in mental health workforce and other major milestones to be reached.			

FY 09/10 funding	FY 10/11 funding	Percent Change

The target population for this program is vulnerable adults, including older adults, and transition age youth (18-25) who are homeless or at risk of homelessness or institutionalization. Adults of all ages and transitional age youth who have been recognized as having untreated mental illness and those who are transitioning from institutional custody (jails, IMDs and psychiatric hospitals) to community-based placement are also served by CSS Adult Wellness and Recovery programs. In addition, the target population includes but is not limited to adults with co-occurring disorders, the Latino and Native American populations, and those who have been significantly under-served in out-of-county Board and Care homes.

The Adult Wellness and Recovery Services program will serve as the umbrella for several programs. Full Service Partnerships (FSPs), as well as outreach and engagement strategies, will be utilized as appropriate to meet client needs.

Resource Management Services (General Systems Development) Program
Managers, supervisors or designees, as assigned, will develop key relationships and build access to resources for the consumers and families served (e.g., housing, vocational, educational, benefits eligibility and substance abuse treatment). MHSA-funded psychiatry time to serve un-insured MHSA clients and engage in general systems development planning to improve access and service delivery is included, as well. In part, the psychiatry time will be used to evaluate and re-design psychiatry services to be effective within our Wellness and Recovery Programs. This component also provides program evaluation and quality improvement oversight for the CSS programs. Funding needs include training and travel (e.g., in data management, quality improvement, and program evaluation) and the personnel, supplies and equipment necessary to administer and score program evaluation, assessment and outcome measures. Food, equipment and supplies may be purchased, as well.

*PEI Projects previously approved are now called Previously Approved Programs

PREVIOUSLY APPROVED PROGRAM

Outreach and Engagement Services (Outreach and Engagement funding)
Mental health professionals, in concert with peer counselors, provide outreach and engagement services for individuals with serious mental illness who are homeless, in the jails, receiving services in primary care, have co-occurring disorders, and who require outreach to their homes – in order to reach the at-risk adult population. Supports such as food, transportation assistance, and emergency shelter may be purchased.

Assertive Community Treatment (ACT) - Full Service Partnership (FSP) funding
A highly individualized and community-based level of intensive case management will be provided via Assertive Community Treatment (ACT) for seriously mentally ill individuals who have co-occurring disorders, and/or are at risk of criminal justice involvement, homelessness and/or institutionalization. Some of these individuals will be eligible for the limited transitional housing beds and/or housing subsidies available for Full Service Partners (FSPs).

The ACT model will be used with severely mentally ill El Dorado County adults who are underserved (in out-of- county Board and Care homes) and/or institutionalized in Institutes of Mental Disease (IMDs) upon readiness for community placement. This component seeks to consolidate dedicated partnerships between clients, family members, the public guardian, courts and housing providers to facilitate recovery and progress toward the least restrictive level of care. Food, household supplies and subsidies, activities and transportation may be funded.

Wellness Center and Clubhouse (General Systems Development funding)
The integrated service delivery system will provide a range of services including but not limited to evidence-based practice interventions[1] both onsite and in community-based settings. Costs for training, materials, associated supports (food, travel, and transportation) and program evaluation are included. As indicated in previous CSS Plans, the Wellness Center provides the setting in which we are building our local capacity to meet the diverse needs of the seriously mentally ill and their families. Collaboration with other disciplines, community-based agencies, NAMI, consumers, and volunteers allows us to provide enhanced services, including family and peer support. Community reintegration activities and life skills training will be provided for Crisis Residential Treatment Facility clients and others deemed appropriate. The target population includes clients who reside in Board and Care Homes. Food and general household supplies may be funded, along with transportation support and petty cash for laundry, toiletries, etc. Individuals who prefer to receive medications alone will be provided case management services to support their ongoing stability.

Crisis Residential Treatment (CRT) Program (General Systems Development)
The CRT is located adjacent to the Psychiatric Health Facility (PHF) and is staffed in part by individuals who provide crisis counseling as part of a 24/7 Psychiatric Emergency Services (PES) response. This team provides proactive measures by which to outreach and engage individuals into various levels of treatment thereby avoiding involuntary care when appropriate. We project that 48 clients will be placed at the CRT each year. The target population for this program includes adults with serious mental illness who meet medical necessity for specialty mental health services and who require 24/7 supervision for a brief period of crisis stabilization or resolution on a voluntary basis, typically as a transition from institutional care (such as a PHF, IMD, psychiatric hospital or residential care) or for those who require a temporary increase in services for stabilization purposes in order to regain a level of functioning needed to maintain their community placement. The services provided include psychiatric assessment, medication stabilization services, individual, family and group counseling, life skills training, community integration activities and 24/7 clinical supervision and residential care. Meals, household supplies, activities and transportation may be funded.

[1] Anger Management, Seeking Safety, and Social and Independent Living Skills, to name just a few options.

2010/11 ANNUAL UPDATE **EXHIBIT D1**

ELIMINATION OF PROGRAM/PROJECT

County: El Dorado

Program/Project Number/ Name: #3 Health Disparities Initiative

Date: 9/28/2010

Select one:

- ☑ CSS
- ☐ WET
- ☐ CF
- ☐ TN
- ☐ PEI[1]
- ☐ INN

1. Clearly identify the program/project proposed for elimination.

Work plan # 3 Health Disparities Initiative: This work plan provides for culturally competent services in appropriate settings to ensure treatment engagement and positive outcomes while strengthening the family unit and serving all age groups. These services are being delivered by local contract providers who were assessed to have the appropriate qualifications to provide bilingual and bicultural mental health services and engagement within Native American and Latino communities.

2. Describe the rationale for eliminating the program/project.

Services funded through this work plan are focused on outreach, engagement, and early intervention. In our FY 09-10 MHSA Annual Update, the County indicated that upon approval of our PEI plan, we would request to transfer this work plan to the PEI program. That PEI plan was approved effective 12/17/2009 and it includes the Health Disparities Initiative component. Consequently, we are removing this work plan from our CSS plan as those activities are now more appropriately funded through PEI.

3. Describe how the funding for the eliminated program/project will be used.

Funding that would have been used for the Health Disparities Initiative will be divided proportionally to the County's ongoing CSS programs: (1) Family Youth and Strengthening and (2) Wellness and Recovery Services.

[1] For PEI only – Counties eliminating a project with funds targeted toward Children, Youth, and Transitional-Aged Youth, the PEI Funding Request (Exhibit E4) should reflect that at least 51% of PEI funds are directed towards individuals under age 25. Small counties are exempt from this requirement. The PEI Program selected for local evaluation may not be eliminated.

FY 2010/11 **EXHIBIT E1**

CSS BUDGET SUMMARY

County: El Dorado **Date:** 28-Sep-10

	CSS Programs		FY 10/11 Requested MHSA Funding	Estimated MHSA Funds by Service Category				Estimated MHSA Funds by Age Group				
	No.	Name		Full Service Partnerships (FSP)	General System Development	Outreach and Engagement	MHSA Housing Program	Children and Youth	Transition Age Youth	Adult	Older Adult	
Previously Approved Programs												
1.	1	Youth and Family Strengthening Program	$588,678	$294,339	$206,037	$88,302		$559,244	$29,434			
2.	2	Adult Wellness and Recovery Services	$2,753,432	$1,530,908	$886,605	$335,919			$275,343	$2,202,746	$275,343	
3.			$0									
4.			$0									
5.			$0									
6.			$0									
7.			$0									
8.			$0									
9.			$0									
10.			$0									
11.			$0									
12.			$0									
13.			$0									
14.			$0									
15.			$0									
16.	Subtotal: Programs [a/]		$3,342,110	$1,825,247	$1,092,642	$424,221	$0	$559,244	$304,777	$2,202,746	$275,343	Percentage
17.	Plus up to 15% County Administration		$828,843									24.8%
18.	Plus up to 10% Operating Reserve		$417,095									10.0%
19.	Subtotal: Previously Approved Programs/County Admin./Operating Reserve		$4,588,048									
New Programs												
1.			$0									
2.			$0									
3.			$0									
4.			$0									
5.			$0									
6.	Subtotal: Programs [a/]		$0	$0	$0	$0	$0	$0	$0	$0	$0	Percentage
7.	Plus up to 15% County Administration											#VALUE!
8.	Plus up to 10% Operating Reserve											#VALUE!
9.	Subtotal: New Programs/County Admin./Operating Reserve		$0									
10.	**Total MHSA Funds Requested for CSS**		$4,588,048									

a/ Majority of funds must be directed towards FSPs (Cal. Code Regs., tit. 9, § 3620, subd. (c)). Percent of Funds directed towards FSPs= 54.60%

Additional funding sources for FSP requirement:
County must provide the majority of MHSA funding toward Full Service Partnerships (FSPs). If not, the county must list what additional funding sources and amount to be used for FSPs. In addition, the funding amounts must match the Annual Cost Report. Refer to DMH FAQs at http://www.dmh.ca.gov/Prop_63/ MHSA/Community_Services_and_Supports/docs/FSP_FAQs_04-17-09.pdf

CSS Majority of Funding to FSPs

		Other Funding Sources									
	CSS	State General Fund	Other State Funds	Medi-Cal FFP	Medicare	Other Federal Funds	Re-alignment	County Funds	Other Funds	Total	Total %
Total Mental Health Expenditures:	$1,825,247	$0	$0	$0	$0	$0	$0	$0	$0	$1,825,247	55%

2010/11 ANNUAL UPDATE **EXHIBIT D**

PREVIOUSLY APPROVED PROGRAM

County: El Dorado

Program Number/Name: ~~**Action #1 - Workforce Education and Training Plan (WET) Coordinator**~~

Date: ~~**September 28, 2010**~~

Select one:

☐ **CSS**
☒ **WET**
☐ **PEI**
☐ **INN**

CSS and WET				
Previously Approved				
No.	**Question**	**Yes**	**No**	
1.	Is this an existing program with no changes?	☐	☒	If yes, answer question #5 and complete Exh.E1 or E2 accordingly; If no, answer question #2
2.	Is there a change in the service population to be served?	☒	☐	If yes, complete Exh. F1; If no, answer question #3
3.	Is there a change in services?	☒	☐	If yes, complete Exh. F1; If no, answer question #4
4.	Is there a change in funding amount for the existing program?	☒	☐	If yes, answer question #4(a); If no, complete Exh. E1or E2 accordingly
a)	Is the change within ±15% of previously approved amount?	☐	☒	If yes, answer question #5 and complete Exh. E1or E2; If no, complete Exh. F1 and complete table below.
5.	**For CSS programs:** Describe the services/strategies and target population to be served. This should include information about targeted age, gender, race/ethnicity and language spoken of the population to be served. **For WET programs:** Describe objectives to be achieved such as days of training, number of scholarships awarded, strategies that expand outreach, recruitment and retention efforts to increase diversity in mental health workforce and other major milestones to be reached.			

FY 09/10 funding	FY 10/11 funding	Percent Change
$ 156,987	$ 101,287	- 35.5%

Annual objectives include: 1) the identification and implementation of one intervention strategy which contributes to a local career pathway construction; 2) the identification and completion of one clinical staff development activity; 3) serve as the County representative on the Rural Mental Health MSW Weekend Program Advisory Board and as the internship liaison; 4) oversight of the Consumer/Family/Volunteer Program Coordination; and 5) serve as the County representative on the Central Regional Partnership Collaborative.

Existing Programs to be Consolidated				
No.	**Question**	**Yes**	**No**	
1.	Is this a consolidation of two or more existing programs?	☐	☒	If yes, answer question #2; If no, answer questions for existing program above
2.	Will all populations of existing program continue to be served?	☐	☐	If yes, answer question #3; If no, complete Exh. F1
3.	Will all services from existing program continue to be offered?	☐	☐	If yes, answer question #4 If no, complete Exh. F1
4.	Is the funding amount ± 15% of the sum of the previously approved amounts?	☐	☐	If yes, answer question #5 and complete Exh. E1 or E2 accordingly If no, complete Exh. F1
5.	Description of Previously Approved Programs to be consolidated. Include in your description: a) The names of Previously Approved programs to be consolidated, b) Describe the target population to be served and the services/strategies to be provided (include targeted age, gender, race/ethnicity, and language spoken by the population to be served)., and c) Provide the rationale for consolidation.			

*PEI Projects previously approved are now called Previously Approved Programs

2010/11 ANNUAL UPDATE **EXHIBIT F1**

CSS and WET NEW PROGRAM DESCRIPTION

County: El Dorado

Program Number/Name: Action #1 – Workforce Education & Training Plan (WET) Coordinator

Date: September 28, 2010

Check boxes that apply:

- ☐ CSS
- ☒ WET
- ☐ New
- ☐ Consolidation
- ☐ Expansion
- ☐ Reduction

NEW PROGRAMS ONLY

CSS and WET

1. Provide narrative description of program. For WET, also include objectives to be achieved.

This Action seeks to both comply with the MHSA requirement to have a designated WET Coordinator and to invest in the provision of leadership for the implementation of the locally identified WET funding priorities.

The MHD seeks to fund a 0.5 FTE position to serve as the MHSA Workforce Education and Training (WET) Coordinator. The reduction in the capacity of this allocation reflects the limits of the funding and the limits of the MHD staffing capacity at this time. The emphasis of the amended WET program will be on the staff development priorities and on the role of capacity building as a critical element of the career pathway.

The annual objectives include: 1) the identification and implementation of one intervention strategy which contributes to a local career pathway construction; 2) the identification and completion of one clinical staff development activity and one capacity building activity; 3) serve as the County representative on the Rural Mental Health MSW Weekend Program Advisory Board and as the internship liaison; 4) oversight of the Consumer/Family/Volunteer Program Coordination; and 5) serve as the County representative on the Central Regional Partnership Collaborative.

2. Explain how the new program is consistent with the priorities identified in the Community Planning Process.

The WET priorities identified in the Community Planning Process were:

- Career Pathway to "grow our own"
- Staff development resources for the existing workforce to support career advancement, improved service delivery, and recruitment and retention.
- ***Supportive infrastructure– including a full-time WET Coordinator to provide internship recruitment and coordination, consumer, family member and volunteer program coordination, and Regional Partnership participation.***

This proposed modification of Action #1 reduces the allocation but retains the commitment to the above priorities identified during the WET CPP process.

3. Provide a description of how the proposed program relates to the General Standards of the MHSA (Cal. Code Regs., tit. 9, § 3320).

This Action incorporates community collaboration through the emphasis on community capacity building via the volunteer program. It also emphasizes the wellness and recovery framework through the career pathways mechanism that will be sustained – the Social and Independent Living Skills (SILS) evidence-based practice training and implementation. The use of the Clubhouse setting for the Volunteer Program ensures that the practice of client-driven services is incorporated within WET program activities. It further promotes a mechanism for service integration – clients can move effectively from consumer status to peer counselor and volunteer status through this training program offered in the context of the Clubhouse setting. Continued participation in the Central Region Partnership Collaborative offers opportunities to improve the cultural competency of mental health systems through training.

CSS and WET NEW PROGRAM DESCRIPTION

WET Only

1. Provide budget justification and clear outline of planning factors used to construct budgeted amount.

The budget provides for personnel (salary, benefits, taxes) and operating expenses (travel, indirect, overhead and facility costs) for a 0.5 FTE WET Coordinator. The total annual cost of this program is $101,287. Of this total, personnel costs (salaries, benefits and taxes) account for $68,856 and associated operating expenses, indirect and overhead expenses total $32,431 annually. In comparison, our previous plan allocated $116,487 for staffing costs plus $40,500 for administrative expenses. Costs have decreased 35.5% for this program primarily as the result of a decrease in the staff allocation from 1.0 to 0.5 FTE. In addition, the County has eliminated several unfunded WET Action plans which had been covered under the WET Coordinator administrative costs.

County: El Dorado Date: 28-Sep-10

Program/Project Name and #: WET #1 Workforce Education and Training Plan (WET) Coordinator

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. EXPENDITURES				
Community Services and Supports				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Expenditures when service provider is not known				$0
6. Non-recurring expenditures				$0
7. Other Expenditures*				$0
8. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Workforce Education and Training				
1. Personnel Expenditures	$68,856			$68,856
2. Operating Expenditures	$32,431			$32,431
3. Training Expenditures				$0
4. Training Consultant Contracts				$0
5. Residency Expenditures				$0
6. Internship Expenditures				$0
7. Mental Health Career Pathway Expenditures				$0
8. Stipend Funds				$0
9. Scholarship Funds				$0
10. Loan Repayment Funds				$0
11. Non-recurring Expenditures				$0
12. Other Expenditures*				$0
13. Total Proposed Expenditures	**$101,287**	**$0**	**$0**	**$101,287**
Capital Facilities				
1. Pre-Development Costs				$0
2. Building/Land Acquisition				$0
3. Renovation				$0
4. Construction				$0
5. Repair/Replacement Reserve				$0
6. Other Expenditures*				$0
7. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Technological Needs				
1. Personnel				$0
2. Hardware				$0
3. Software				$0
4. Contract Services				$0
5. Other Expenditures*				$0
6. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Prevention and Early Intervention (PEI)				
1. Personnel				$0
2. Operating Expenditures				$0
3. Non-recurring Expenditures				$0
4. Subcontracts/Professional Services				$0
5. Other				$0
6. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**

Innovation (INN)						
	1. Personnel					$0
	2. Operating Expenditures					$0
	3. Non-recurring Expenditures					$0
	4. Training Consultant Contracts					$0
	5. Work Plan Management					$0
	6. Other					$0
	7. Total Proposed Expenditures		**$0**	**$0**	**$0**	**$0**
B. REVENUES						
	1. New Revenues					
	a. Medi-Cal (FFP only)					$0
	b. State General Funds					$0
	c. Other Revenue					$0
	2. Total Revenues		**$0**	**$0**	**$0**	**$0**
C. TOTAL FUNDING REQUESTED			**$101,287**	**$0**	**$0**	**$101,287**

***Enter the justification for items that are requested under the "Other Expenditures" category.**

Justification:

Please include your budget narrative on a separate page.

Prepared by: Janet Stevens

Telephone Number: (530) 621-6226

WET NEW PROGRAM DESCRIPTION EXHIBIT F cont.
BUDGET NARRATIVE

Action #1 – WET Coordinator

The budget provides for personnel (salary, benefits, taxes) and operating expenses (travel, indirect, overhead and facility costs) for a 0.5 FTE WET Coordinator. The total annual cost of this program is $101,287. Of this total, personnel costs (salaries, benefits and taxes) account for $68,856 and associated operating expenses, indirect and overhead expenses total $32,431 annually. In comparison, our previous plan allocated $116,487 for staffing costs plus $40,500 for administrative expenses. Costs have decreased 35.5% for this program primarily as the result of a decrease in the staff allocation from 1.0 to 0.5 FTE. In addition, the County has eliminated several unfunded WET Action plans which had been covered under the WET Coordinator administrative costs.

2010/11 ANNUAL UPDATE **EXHIBIT D**

PREVIOUSLY APPROVED PROGRAM

County: El Dorado

Program Number/Name: Action #2a - Workforce Development through the Network-of-Care e-Learning Technology

Date: September 28, 2010

Select one:
☐ **CSS**
☒ **WET**
☐ **PEI**
☐ **INN**

CSS and WET				
Previously Approved				
No.	**Question**	**Yes**	**No**	
1.	Is this an existing program with no changes?	☐	☒	If yes, answer question #5 and complete Exh.E1 or E2 accordingly; If no, answer question #2
2.	Is there a change in the service population to be served?	☒	☐	If yes, complete Exh. F1; If no, answer question #3
3.	Is there a change in services?	☒	☐	If yes, complete Exh. F1; If no, answer question #4
4.	Is there a change in funding amount for the existing program?	☒	☐	If yes, answer question #4(a); If no, complete Exh. E1or E2 accordingly
a)	Is the change within ±15% of previously approved amount?	☒	☐	If yes, answer question #5 and complete Exh. E1or E2; If no, complete Exh. F1 and complete table below.
				FY 09/10 funding | **FY 10/11 funding** | **Percent Change**
				| | |
5.	**For CSS programs:** Describe the services/strategies and target population to be served. This should include information about targeted age, gender, race/ethnicity and language spoken of the population to be served. **For WET programs:** Describe objectives to be achieved such as days of training, number of scholarships awarded, strategies that expand outreach, recruitment and retention efforts to increase diversity in mental health workforce and other major milestones to be reached.			
Annual objectives include: 1) establishment of a contract to provide e-learning opportunities for MHD clinical staff and the community; 2) identification of training priorities for MHD staff development and capacity building purposes; 3) implementation of at least one staff development and at least one capacity building training event; and 4) collaboration with the Ethnic Services Coordinator to ensure compliance with the Cultural Competency training requirements.				
Existing Programs to be Consolidated				
No.	**Question**	**Yes**	**No**	
1.	Is this a consolidation of two or more existing programs?	☐	☒	If yes, answer question #2; If no, answer questions for existing program above
2.	Will all populations of existing program continue to be served?	☐	☐	If yes, answer question #3; If no, complete Exh. F1
3.	Will all services from existing program continue to be offered?	☐	☐	If yes, answer question #4 If no, complete Exh. F1
4.	Is the funding amount ± 15% of the sum of the previously approved amounts?	☐	☐	If yes, answer question #5 and complete Exh. E1 or E2 accordingly If no, complete Exh. F1
5.	Description of Previously Approved Programs to be consolidated. Include in your description: a) The names of Previously Approved programs to be consolidated, b) Describe the target population to be served and the services/strategies to be provided (include targeted age, gender, race/ethnicity, and language spoken by the population to be served)., and c) Provide the rationale for consolidation.			

*PEI Projects previously approved are now called Previously Approved Programs

2010/11 ANNUAL UPDATE **EXHIBIT F1**

CSS and WET NEW PROGRAM DESCRIPTION

County: El Dorado

Program Number/Name: Action #2 – Workforce Development

Date: September 28, 2010

Check boxes that apply:
- ☐ **CSS**
- ☒ **WET**
- ☐ **New**
- ☐ **Consolidation**
- ☐ **Expansion**
- ☐ **Reduction**

NEW PROGRAMS ONLY

CSS and WET

1. Provide narrative description of program. For WET, also include objectives to be achieved.

This Action was previously number 2a. Action 2b is proposed to be eliminated and therefore this Action will be identified as Action #2.

This Action is also being renamed – to a broader title – Workforce Development.

This Action is being modified to include a broader array of staff development, training, and community capacity building training supported by WET funds. Stakeholder feedback promoting this strategy has been received since the approval of the WET plan. In addition, evaluation by the External Quality Review Organization (EQRO) has indicated that staff development activities should be enhanced.

The goal of establishing an e-learning resource for both staff and the community continues – various vendors are being considered at this time. However, this modification is also intended to provide options in training modalities so that we can access the most effective resources by which to provide the training and skills necessary to ensure the delivery of recovery-oriented, culturally competent, consumer-driven and family member-driven services through collaboration with community partners. An emphasis will be placed on investing in training in the use of evidence-based practices where available.

The WET Coordinator will be responsible for implementing this Action. Staffing support for some of these activities may also be covered by the WET allocation. MHSA WET funds may be used for a broad range of staff development, training and community capacity-building activities and associated costs (including but not limited to travel, food, and materials). To date, the following training priorities have been identified by stakeholders:

- Evidence-based practices for youth
- Training related to various co-occurring disorders that impact the mental health disorder in both youth and adult populations
- Strategies for readiness related to healthcare reform
- Training related to electronic health records systems
- Supervision and leadership training
- Cultural competency trainings (including a full-range of health disparity issues – not restricted to issues related to race and ethnicity)
- Recovery and resiliency training
- Consumer Leadership Academy
- Training designed to assist multi-disciplinary teams in improved integrated service delivery

Furthermore, the provision of resources to ensure fidelity to treatment models, program evaluation and effective standardized assessment and outcome measures is critical to the establishment of a

strong workforce and to this end, MHSA WET funding may be applied.

Annual objectives include: 1) establishment of a contract to provide e-learning opportunities for MHD clinical staff and the community; 2) identification of training priorities for MHD staff development and capacity building purposes; 3) implementation of at least one staff development and at least one capacity building training event annually; and 4) collaboration with the Ethnic Services Coordinator to ensure compliance with the Cultural Competency training requirements.

2. Explain how the new program is consistent with the priorities identified in the Community Planning Process.

The findings of the MHSA WET CPP process included the identification of the need to provide staff development resources for the existing workforce to support career advancement, improved service delivery, and to assist in recruitment and retention. More recent community planning discussions have also identified community capacity building – in part through training opportunities – as a current priority. MHSA WET funds are an effective resource for these community-identified priorities.

3. Provide a description of how the proposed program relates to the General Standards of the MHSA (Cal. Code Regs., tit. 9, § 3320).

This Action incorporates community collaboration through the emphasis on community capacity building via the provision of training opportunities. This approach includes an emphasis on training resources that focus on resilience, wellness and recovery. A client-driven framework approach will be taken in regard to seeking consumer input related to training opportunities that they may wish to have provided and available to them, as well as asking for feedback regarding the types of service strategies that they feel are needed and desired thereby identifying a staff training need. This Action further promotes service integration through both the inclusive training approach, as well as the inclusion of training specifically related to service integration strategies and co-occurring disorders. Finally, addressing health disparities will continue to be a large emphasis of the training needs served, in conjunction with ensuring compliance with the cultural competency requirements related to staff training.

WET Only

1. Provide budget justification and clear outline of planning factors used to construct budgeted amount.

In collaboration with staff, consumers and stakeholder groups, the County has identified high-priority staff development, training and community capacity-building activities to be funded through this plan. Budgeting allows for a broad range of staff development, training and community capacity-building activities and associated costs to be provided through subcontracts and professional services. We have included an annual budget allocation of $6,687 to fund web-based educational curriculum for professional and medical staff. In addition, we expect to fund and host at least one staff development and at least one capacity building training event annually. We plan to focus on providing the training and skill-development necessary to ensure the delivery of recovery-oriented, culturally competent services, and will implement training in the use of evidence-based practices when possible. The funding request includes an allowance for travel, food, and materials as well.

CSS and WET NEW PROGRAM DESCRIPTION

Given that training costs, staff participation, time requirements and training alternatives may vary, we have constructed a budget that is consistent with our previous Workforce Development plan, increased by 15%. Total budgeted amount, $27,600.

County: El Dorado Date: 28-Sep-10

Program/Project Name and #: WET #2 Workforce Development

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. EXPENDITURES				
Community Services and Supports				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Expenditures when service provider is not known				$0
6. Non-recurring expenditures				$0
7. Other Expenditures*				$0
8. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Workforce Education and Training				
1. Personnel Expenditures				$0
2. Operating Expenditures			$7,000	$7,000
3. Training Expenditures	$15,000			$15,000
4. Training Consultant Contracts			$5,600	$5,600
5. Residency Expenditures				$0
6. Internship Expenditures				$0
7. Mental Health Career Pathway Expenditures				$0
8. Stipend Funds				$0
9. Scholarship Funds				$0
10. Loan Repayment Funds				$0
11. Non-recurring Expenditures				$0
12. Other Expenditures*				$0
13. Total Proposed Expenditures	**$15,000**	**$0**	**$12,600**	**$27,600**
Capital Facilities				
1. Pre-Development Costs				$0
2. Building/Land Acquisition				$0
3. Renovation				$0
4. Construction				$0
5. Repair/Replacement Reserve				$0
6. Other Expenditures*				$0
7. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Technological Needs				
1. Personnel				$0
2. Hardware				$0
3. Software				$0
4. Contract Services				$0
5. Other Expenditures*				$0
6. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Prevention and Early Intervention (PEI)				
1. Personnel				$0
2. Operating Expenditures				$0
3. Non-recurring Expenditures				$0
4. Subcontracts/Professional Services				$0
5. Other				$0
6. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**

Innovation (INN)						
	1. Personnel					$0
	2. Operating Expenditures					$0
	3. Non-recurring Expenditures					$0
	4. Training Consultant Contracts					$0
	5. Work Plan Management					$0
	6. Other					$0
	7. Total Proposed Expenditures		**$0**	**$0**	**$0**	**$0**
B. REVENUES						
	1. New Revenues					
	a. Medi-Cal (FFP only)					$0
	b. State General Funds					$0
	c. Other Revenue					$0
	2. Total Revenues		**$0**	**$0**	**$0**	**$0**
C. TOTAL FUNDING REQUESTED			**$15,000**	**$0**	**$12,600**	**$27,600**

***Enter the justification for items that are requested under the "Other Expenditures" category.**

Justification:

Please include your budget narrative on a separate page.

Prepared by: Janet Stevens

Telephone Number: (530) 621-6226

WET NEW PROGRAM DESCRIPTION EXHIBIT F cont.
BUDGET NARRATIVE

Action #2 – Workforce Development

In collaboration with staff, consumers and stakeholder groups, the County has identified high-priority staff development, training and community capacity-building activities to be funded through this plan. Budgeting allows for a broad range of staff development, training and community capacity-building activities and associated costs to be provided through subcontracts and professional services. We have included an annual budget allocation of $6,687 to fund web-based educational curriculum for professional and medical staff. In addition, we expect to fund and host at least one staff development and at least one capacity building training event annually. We plan to focus on providing the training and skill-development necessary to ensure the delivery of recovery-oriented, culturally competent services, and will implement training in the use of evidence-based practices when possible. The funding request includes an allowance for travel, food, and materials as well.

Given that training costs, staff participation, time requirements and training alternatives may vary, we have constructed a budget that is consistent with our previous Workforce Development plan, increased by 15%.

Total budgeted amount, $27,600

2010/11 ANNUAL UPDATE **EXHIBIT D1**

ELIMINATION OF PROGRAM/PROJECT

County: El Dorado

Program/Project Number/ Name: #2b Clinical Outcomes Measures for the Behavioral Health Court Program

Date: 9/28/2010

Select one:
- ☐ CSS
- ☑ WET
- ☐ CF
- ☐ TN
- ☐ PEI[1]
- ☐ INN

1. Clearly identify the program/project proposed for elimination.
Action # 2b: This action was designed to fund consultation and technical assistance in order to establish a clinical outcomes measurement system, and to strengthen cultural competency in a community team that serves seriously mentally ill adults who are incarcerated as a function of untreated mental illness.
2. Describe the rationale for eliminating the program/project.
Implementation of this program was not feasible due to the limited capacity of the Behavioral Health Court Program. Instead, a CIOM (Clinically Informed Outcomes Management) program has been implemented with all adult clients enrolled in outpatient programs on the West Slope of El Dorado County.
3. Describe how the funding for the eliminated program/project will be used.
Funds will be used to maintain ongoing WET programs.

[1] For PEI only – Counties eliminating a project with funds targeted toward Children, Youth, and Transitional-Aged Youth, the PEI Funding Request (Exhibit E4) should reflect that at least 51% of PEI funds are directed towards individuals under age 25. Small counties are exempt from this requirement. The PEI Program selected for local evaluation may not be eliminated.

2010/11 ANNUAL UPDATE **EXHIBIT D**

PREVIOUSLY APPROVED PROGRAM

County: El Dorado

Program Number/Name: Action #3 - Workforce Development through Psychiatric Rehabilitation Training

Date: September 28, 2010

Select one:
- ☐ **CSS**
- ☒ **WET**
- ☐ **PEI**
- ☐ **INN**

CSS and WET				
Previously Approved				
No.	**Question**	**Yes**	**No**	
1.	Is this an existing program with no changes?	☐	☒	If yes, answer question #5 and complete Exh.E1 or E2 accordingly; If no, answer question #2
2.	Is there a change in the service population to be served?	☐	☒	If yes, complete Exh. F1; If no, answer question #3
3.	Is there a change in services?	☒	☐	If yes, complete Exh. F1; If no, answer question #4
4.	Is there a change in funding amount for the existing program?	☒	☐	If yes, answer question #4(a); If no, complete Exh. E1or E2 accordingly
a)	Is the change within ±15% of previously approved amount?	☐	☒	If yes, answer question #5 and complete Exh. E1or E2; If no, complete Exh. F1 and complete table below.

FY 09/10 funding	FY 10/11 funding	Percent Change
0	$31,760	100%

5.	**For CSS programs:** Describe the services/strategies and target population to be served. This should include information about targeted age, gender, race/ethnicity and language spoken of the population to be served. **For WET programs:** Describe objectives to be achieved such as days of training, number of scholarships awarded, strategies that expand outreach, recruitment and retention efforts to increase diversity in mental health workforce and other major milestones to be reached.
Annual objectives include: 1) Consultation with Center for Psychiatric Rehabilitation; 2) purchase of training materials; and 3) development of training plan for FY11/12	

Existing Programs to be Consolidated				
No.	**Question**	**Yes**	**No**	
1.	Is this a consolidation of two or more existing programs?	☐	☒	If yes, answer question #2; If no, answer questions for existing program above
2.	Will all populations of existing program continue to be served?	☐	☐	If yes, answer question #3; If no, complete Exh. F1
3.	Will all services from existing program continue to be offered?	☐	☐	If yes, answer question #4 If no, complete Exh. F1
4.	Is the funding amount ± 15% of the sum of the previously approved amounts?	☐	☐	If yes, answer question #5 and complete Exh. E1 or E2 accordingly If no, complete Exh. F1
5.	Description of Previously Approved Programs to be consolidated. Include in your description: a) The names of Previously Approved programs to be consolidated, b) Describe the target population to be served and the services/strategies to be provided (include targeted age, gender, race/ethnicity, and language spoken by the population to be served)., and c) Provide the rationale for consolidation.			

*PEI Projects previously approved are now called Previously Approved Programs

2010/11 ANNUAL UPDATE **EXHIBIT F1**

CSS and WET NEW PROGRAM DESCRIPTION

County: El Dorado

Program Number/Name: Action #3 - Workforce Development through Psychiatric Rehabilitation Training

Date: September 28, 2010

Check boxes that apply:

- ☐ CSS
- ☒ WET
- ☐ New
- ☐ Consolidation
- ☐ Expansion
- ☐ Reduction

NEW PROGRAMS ONLY

CSS and WET

1. Provide narrative description of program. For WET, also include objectives to be achieved.

The Social and Independent Livings Skills (SILS) program has been implemented in the WS and SLT adult Wellness Centers. Staff, contract providers, consumers, family members, volunteers and some middle and high school students have received training. We anticipate continuation of this program as an entry-level career ladder opportunity and a community capacity building strategy under CSS Plan #2.

Based on a recommendation presented by the El Dorado County Mental Health Commission, this Action shall be used to bring a new training program – the Psychiatric Rehabilitation Training Technology – from Boston University. The Center for Psychiatric Rehabilitation of the Sargent College of Health and Rehabilitation Sciences at Boston University has developed a training technology to teach the critical skills needed by practitioners to assist consumers through the rehabilitation process. In psychiatric rehabilitation, the goals are related to reducing the disability and handicap for persons with long-term psychiatric disabilities. The training program has been extensively field-tested and under a NIMH (National Institute for Mental Health) grant, hundreds of trainers have been trained. In addition, the Center has produced five training technology packages that can be used independent of Center training staff. The packages include:

- Rehabilitation Readiness
- Setting an Overall Rehabilitation Goal
- Functional Assessment
- Direct Skills Teaching
- Case Management.

The training technology packages provided detailed procedures for developing competence and a systematic training program that can be used by any trainer.

The Direct Skills Teaching curricula will be applied, as well as training through Recovery Workbooks (English and Spanish), Food Education for People with Serious Psychiatric Disabilities: An Evidence-based Recovery Curriculum, and a training module in the Role of the Family in Psychiatric Rehabilitation.

This Action previously was identified as a “no cost” program to the MHSA WET allocation; however, it is apparent that the administrative support for this effort does require resources. In addition, we may utilize a consultant to provide training and assistance in program evaluation. Therefore, this program amendment largely reflects a change in the rehabilitation approach applied and an allocation of funds to support administrative costs incurred.

Annual objectives include: 1) Consultation with the Center for Psychiatric Rehabilitation; 2) purchase of training materials; and 3) development of a training plan for FY 11/12.

2. Explain how the new program is consistent with the priorities identified in the Community Planning Process.

This Action addresses two of the priority workforce education and training needs identified by the community:

- Career Pathway to “grow our own”
- Community capacity building

The overarching goal of this training will be to expand the mental health workforce in a diverse and collaborative fashion by providing Psychiatric Rehabilitation training in modules which have demonstrated success with adults suffering from serious mental illness.

CSS and WET NEW PROGRAM DESCRIPTION

3. Provide a description of how the proposed program relates to the General Standards of the MHSA (Cal. Code Regs., tit. 9, § 3320).

This Action incorporates community collaboration through the emphasis on community capacity building. It also emphasizes the wellness and recovery framework through the Psychiatric Rehabilitation training model. Service integration is provided as consumers have the opportunity to move from recipient of the group services to teacher. The practice of client-driven services is incorporated in this effort toward consumer inclusion and empowerment in service delivery. Improvement in the system's cultural competency is addressed as the pool of trainers become increasingly diverse.

WET Only

1. Provide budget justification and clear outline of planning factors used to construct budgeted amount.

The funding allocated to this program will be used in support of a Mental Health Program Coordinator (0.1 FTE salary and benefits) and to utilize some professional services for training and assistance in program evaluation. In addition we have included the indirect and overhead costs associated with this position, and have added funds to cover the costs of food, travel and the materials that are needed for the presentation of Psychiatric Rehabilitation training workshops. Total program budget, $31,760

County: El Dorado Date: 28-Sep-10

Program/Project Name and #: WET #3 Workforce Development through Psychiatric Rehabilitation Training

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. EXPENDITURES				
Community Services and Supports				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Expenditures when service provider is not known				$0
6. Non-recurring expenditures				$0
7. Other Expenditures*				$0
8. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Workforce Education and Training				
1. Personnel Expenditures	$16,771			$16,771
2. Operating Expenditures	$14,989			$14,989
3. Training Expenditures				$0
4. Training Consultant Contracts				$0
5. Residency Expenditures				$0
6. Internship Expenditures				$0
7. Mental Health Career Pathway Expenditures				$0
8. Stipend Funds				$0
9. Scholarship Funds				$0
10. Loan Repayment Funds				$0
11. Non-recurring Expenditures				$0
12. Other Expenditures*				$0
13. Total Proposed Expenditures	**$31,760**	**$0**	**$0**	**$31,760**
Capital Facilities				
1. Pre-Development Costs				$0
2. Building/Land Acquisition				$0
3. Renovation				$0
4. Construction				$0
5. Repair/Replacement Reserve				$0
6. Other Expenditures*				$0
7. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Technological Needs				
1. Personnel				$0
2. Hardware				$0
3. Software				$0
4. Contract Services				$0
5. Other Expenditures*				$0
6. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Prevention and Early Intervention (PEI)				
1. Personnel				$0
2. Operating Expenditures				$0
3. Non-recurring Expenditures				$0
4. Subcontracts/Professional Services				$0
5. Other				$0
6. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**

Innovation (INN)						
	1. Personnel					$0
	2. Operating Expenditures					$0
	3. Non-recurring Expenditures					$0
	4. Training Consultant Contracts					$0
	5. Work Plan Management					$0
	6. Other					$0
	7. Total Proposed Expenditures		**$0**	**$0**	**$0**	**$0**
B. REVENUES						
	1. New Revenues					
	a. Medi-Cal (FFP only)					$0
	b. State General Funds					$0
	c. Other Revenue					$0
	2. Total Revenues		**$0**	**$0**	**$0**	**$0**
C. TOTAL FUNDING REQUESTED			**$31,760**	**$0**	**$0**	**$31,760**

***Enter the justification for items that are requested under the "Other Expenditures" category.**

Justification:

Please include your budget narrative on a separate page.

Prepared by: Janet Stevens

Telephone Number: (530) 621-6226

WET NEW PROGRAM DESCRIPTION EXHIBIT F cont.
BUDGET NARRATIVE

Action #3 – Workforce Development through Psychiatric Rehabilitation Training

The funding allocated to this program will be used in support of a Mental Health Program Coordinator (0.1 FTE salary and benefits) and to utilize some professional services for training and assistance in program evaluation. In addition we have included the indirect and overhead costs associated with this position, and have added funds to cover the costs of food, travel and the materials that are needed for the presentation of Psychiatric Rehabilitation training.

Total program budget, $31,760

2010/11 ANNUAL UPDATE **EXHIBIT D1**

ELIMINATION OF PROGRAM/PROJECT

Select one:
- ☐ **CSS**
- ☑ **WET**
- ☐ **CF**
- ☐ **TN**
- ☐ **PEI**[1]
- ☐ **INN**

County: El Dorado

Program/Project Number/ Name: #4 Career Pathways to "Grow Our Own" Workforce: El Dorado High School Health and Human Services Academy

Date: 9/28/2010

1. Clearly identify the program/project proposed for elimination.
Action # 4: Career Pathways to "Grow Our Own" Workforce: El Dorado High School Health and Human Services Academy. This work plan was offered in cooperation with the El Dorado High School Health Careers Academy and was available to high school seniors. The program offered classroom and field experience in partnership with the Mental Health Division staff. Oversight was provided by the WET Coordinator in collaboration with the high school's Health Education Coordinator.
2. Describe the rationale for eliminating the program/project.
Student interest in this program was less than expected.
3. Describe how the funding for the eliminated program/project will be used.
This program was unfunded.

[1] For PEI only – Counties eliminating a project with funds targeted toward Children, Youth, and Transitional-Aged Youth, the PEI Funding Request (Exhibit E4) should reflect that at least 51% of PEI funds are directed towards individuals under age 25. Small counties are exempt from this requirement. The PEI Program selected for local evaluation may not be eliminated.

2010/11 ANNUAL UPDATE **EXHIBIT D**

PREVIOUSLY APPROVED PROGRAM

County: El Dorado

Select one:
☐ **CSS**
☒ **WET**
☐ **PEI**
☐ **INN**

Program Number/Name: Action # 5 - Career Pathways to "Grow Our Own" Workforce: Rural Mental Health MSW Weekend Program at CSU Sacramento

Date: September 28, 2010

CSS and WET				
Previously Approved				
No.	**Question**	**Yes**	**No**	
1.	Is this an existing program with no changes?	☐	☒	If yes, answer question #5 and complete Exh.E1 or E2 accordingly; If no, answer question #2
2.	Is there a change in the service population to be served?	☐	☒	If yes, complete Exh. F1; If no, answer question #3
3.	Is there a change in services?	☐	☒	If yes, complete Exh. F1; If no, answer question #4
4.	Is there a change in funding amount for the existing program?	☒	☐	If yes, answer question #4(a); If no, complete Exh. E1or E2 accordingly
a)	Is the change within ±15% of previously approved amount?	☐	☒	If yes, answer question #5 and complete Exh. E1or E2; If no, complete Exh. F1 and complete table below.
5.	**For CSS programs:** Describe the services/strategies and target population to be served. This should include information about targeted age, gender, race/ethnicity and language spoken of the population to be served. **For WET programs:** Describe objectives to be achieved such as days of training, number of scholarships awarded, strategies that expand outreach, recruitment and retention efforts to increase diversity in mental health workforce and other major milestones to be reached.			
Annual objectives include: 1) use of MHSA WET funds to collaboratively fund a portion of the administrative costs as allowable by contract and MOU; 2) provision of field placements and related supervision for program students; and 3) participation on the Rural MH MSW Weekend Program Advisory Board.				
Existing Programs to be Consolidated				
No.	**Question**	**Yes**	**No**	
1.	Is this a consolidation of two or more existing programs?	☐	☒	If yes, answer question #2; If no, answer questions for existing program above
2.	Will all populations of existing program continue to be served?	☐	☐	If yes, answer question #3; If no, complete Exh. F1
3.	Will all services from existing program continue to be offered?	☐	☐	If yes, answer question #4 If no, complete Exh. F1
4.	Is the funding amount ± 15% of the sum of the previously approved amounts?	☐	☐	If yes, answer question #5 and complete Exh. E1 or E2 accordingly If no, complete Exh. F1
5.	Description of Previously Approved Programs to be consolidated. Include in your description: a) The names of Previously Approved programs to be consolidated, b) Describe the target population to be served and the services/strategies to be provided (include targeted age, gender, race/ethnicity, and language spoken by the population to be served)., and c) Provide the rationale for consolidation.			

FY 09/10 funding	FY 10/11 funding	Percent Change
$ 55,500	$ 26,029	- 53.1%

*PEI Projects previously approved are now called Previously Approved Programs

CSS and WET NEW PROGRAM DESCRIPTION

County: El Dorado

Program Number/Name: Action #4 – Career Pathways to "Grow Our Own" Workforce: Rural Mental Health MSW Weekend Program at CSU Sacramento

Date: September 28, 2010

NEW PROGRAMS ONLY

CSS and WET

1. Provide narrative description of program. For WET, also include objectives to be achieved.

This Action was formerly #5 but as Action #4 has been proposed for elimination, this Action has been renumbered.

El Dorado County is joining with Calaveras, Tuolumne, Amador Counties and the Central Regional Collaborative in funding the administrative costs to pilot a rural mental health weekend MSW program at CSU Sacramento. This allows local students to maintain full-time employment while acquiring their masters thereby targeting individuals who are established in the local community and therefore interested in retaining employment here upon graduation.

In addition to the MHSA WET funding provided, the WET Coordinator supports this Action by participating on the programs Advisory Committee and serving as the liaison for field placements at the MHD.

Annual objectives include: 1) use of MHSA WET funds to collaboratively fund a portion of the administrative costs as allowable by contract and MOU; 2) provision of field placements and related supervision for program students; and 3) participation on the Rural MH MSW Weekend Program Advisory Board.

2. Explain how the new program is consistent with the priorities identified in the Community Planning Process.

This Action addresses the priority workforce education and training needed to establish a career pathway. It specifically addresses the issues identified in the workforce needs assessment related to the need for increased licensed clinicians in El Dorado County. The weekend program, with the rural mental health focus, is targeting working adults who may want to remain in our community upon completing their graduate studies.

3. Provide a description of how the proposed program relates to the General Standards of the MHSA (Cal. Code Regs., tit. 9, § 3320).

This Action incorporates community collaboration through the collaborative efforts with the local university and county partners. It also emphasizes the wellness and recovery framework through the MHSA-focused curriculum. Field placements and academic materials addressing practices of client-driven, integrated and culturally competent services are also part of the training program.

CSS and WET NEW PROGRAM DESCRIPTION

WET Only
1. Provide budget justification and clear outline of planning factors used to construct budgeted amount.
Administrative funding for the MSW program provides the salary for staff program coordination, clerical support, travel and supplies. This funding agreement was negotiated with University Enterprises, Inc, fiscal agent for CSU Sacramento, not to exceed $100,000 annually. In the original plan, El Dorado County was to partner with Calaveras, Tuolumne, and Amador Counties to sponsor this program. In the course of implementation, the Central Region Partnership was added to the partnership and the County's share was reduced. In FY 2009/10 the El Dorado County share was 16% ($16,000). In our planning and budgeting, we anticipate that the level of expenditures for this program will not exceed that of the first year; thus we've budgeted an NTE of $16,000 for FY 10/11 to fund El Dorado County's continued participation in this pilot program. In addition, we've budgeted 0.05 FTE Mental Health Program Coordinator to provide field placement and related supervision for program students and to participate in the Rural MH MSW Weekend Program Advisory Board. Total program budget, $26,029

County: El Dorado Date: 28-Sep-10

Program/Project Name and #: WET #4 Career Pathways to "Grow Our Own" Workforce: Rural Mental Health MSW Weekend Program at CSU Sacramento

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. EXPENDITURES				
Community Services and Supports				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Expenditures when service provider is not known				$0
6. Non-recurring expenditures				$0
7. Other Expenditures*				$0
8. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Workforce Education and Training				
1. Personnel Expenditures	$6,886			$6,886
2. Operating Expenditures	$3,143			$3,143
3. Training Expenditures				$0
4. Training Consultant Contracts				$0
5. Residency Expenditures				$0
6. Internship Expenditures				$0
7. Mental Health Career Pathway Expenditures			$16,000	$16,000
8. Stipend Funds				$0
9. Scholarship Funds				$0
10. Loan Repayment Funds				$0
11. Non-recurring Expenditures				$0
12. Other Expenditures*				$0
13. Total Proposed Expenditures	**$10,029**	**$0**	**$16,000**	**$26,029**
Capital Facilities				
1. Pre-Development Costs				$0
2. Building/Land Acquisition				$0
3. Renovation				$0
4. Construction				$0
5. Repair/Replacement Reserve				$0
6. Other Expenditures*				$0
7. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Technological Needs				
1. Personnel				$0
2. Hardware				$0
3. Software				$0
4. Contract Services				$0
5. Other Expenditures*				$0
6. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Prevention and Early Intervention (PEI)				
1. Personnel				$0
2. Operating Expenditures				$0
3. Non-recurring Expenditures				$0
4. Subcontracts/Professional Services				$0
5. Other				$0
6. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**

Innovation (INN)						
	1. Personnel					$0
	2. Operating Expenditures					$0
	3. Non-recurring Expenditures					$0
	4. Training Consultant Contracts					$0
	5. Work Plan Management					$0
	6. Other					$0
	7. Total Proposed Expenditures		**$0**	**$0**	**$0**	**$0**
B. REVENUES						
	1. New Revenues					
	a. Medi-Cal (FFP only)					$0
	b. State General Funds					$0
	c. Other Revenue					$0
	2. Total Revenues		**$0**	**$0**	**$0**	**$0**
C. TOTAL FUNDING REQUESTED			**$10,029**	**$0**	**$16,000**	**$26,029**

***Enter the justification for items that are requested under the "Other Expenditures" category.**

Justification:

Please include your budget narrative on a separate page.

Prepared by: Janet Stevens

Telephone Number: (530) 621-6226

WET NEW PROGRAM DESCRIPTION EXHIBIT F cont.
BUDGET NARRATIVE

Action #4 – Workforce Development the Rural Mental Health MSW Weekend Program

Administrative funding for the MSW program provides the salary for staff program coordination, clerical support, travel and supplies. This funding agreement was negotiated with University Enterprises, Inc, fiscal agent for CSU Sacramento, not to exceed $100,000 annually. In the original plan, El Dorado County was to partner with Calaveras, Tuolumne, and Amador Counties to sponsor this program. In the course of implementation, the Central Region Partnership was added to the partnership and the County's share was reduced. In FY 2009/10 the El Dorado County share was 16% ($16,000). In our planning and budgeting, we anticipate that the level of expenditures for this program will not exceed that of the first year; thus we've budgeted an NTE of $16,000 for FY 10/11 to fund El Dorado County's continued participation in this pilot program. In addition, we've budgeted 0.05 FTE Mental Health Program Coordinator to provide field placement and related supervision for program students and to participate in the Rural MH MSW Weekend Program Advisory Board.

Total program budget, $26,029

2010/11 ANNUAL UPDATE **EXHIBIT D1**

ELIMINATION OF PROGRAM/PROJECT

County: El Dorado

Program/Project Number/ Name: #6 Coordination of Interagency internships and clinical group supervision

Date: 9/28/2010

Select one:
- ☐ CSS
- ☑ WET
- ☐ CF
- ☐ TN
- ☐ PEI[1]
- ☐ INN

1. Clearly identify the program/project proposed for elimination.
Action # 6: Coordination of Interagency internships and clinical group supervision. This work plan was designed to enhance the career pathway and appeal of training and working in El Dorado County by establishing an enriched training opportunity. Further, the work plan aimed to improve inter-agency collaboration in the area of clinical supervision.
2. Describe the rationale for eliminating the program/project.
The WET Coordinator capacity has been reduced. In addition, interagency collaboration will be provided through Program #2 in which training will continue to be made available to County partners. Internships at the MHD are continuing to be made available, as well.
3. Describe how the funding for the eliminated program/project will be used.
This program was unfunded.

[1] For PEI only – Counties eliminating a project with funds targeted toward Children, Youth, and Transitional-Aged Youth, the PEI Funding Request (Exhibit E4) should reflect that at least 51% of PEI funds are directed towards individuals under age 25. Small counties are exempt from this requirement. The PEI Program selected for local evaluation may not be eliminated.

2010/11 ANNUAL UPDATE **EXHIBIT D**

PREVIOUSLY APPROVED PROGRAM

County: El Dorado

Select one:
☐ **CSS**
☒ **WET**
☐ **PEI**
☐ **INN**

Program Number/Name: Action #7 - Consumer and Family Member and Volunteer Program
Date: ~~September 28, 2010~~

CSS and WET				
Previously Approved				
No.	**Question**	**Yes**	**No**	
1.	Is this an existing program with no changes?	☐	☒	If yes, answer question #5 and complete Exh.E1 or E2 accordingly; If no, answer question #2
2.	Is there a change in the service population to be served?	☐	☒	If yes, complete Exh. F1; If no, answer question #3
3.	Is there a change in services?	☐	☒	If yes, complete Exh. F1; If no, answer question #4
4.	Is there a change in funding amount for the existing program?	☒	☐	If yes, answer question #4(a); If no, complete Exh. E1or E2 accordingly
a)	Is the change within ±15% of previously approved amount?	☐	☒	If yes, answer question #5 and complete Exh. E1or E2; If no, complete Exh. F1 and complete table below.

FY 09/10 funding	FY 10/11 funding	Percent Change
$ 49,013	$ 75,305	53.6%

5.	**For CSS programs:** Describe the services/strategies and target population to be served. This should include information about targeted age, gender, race/ethnicity and language spoken of the population to be served. **For WET programs:** Describe objectives to be achieved such as days of training, number of scholarships awarded, strategies that expand outreach, recruitment and retention efforts to increase diversity in mental health workforce and other major milestones to be reached.
Annual objectives include: 1) recruit, orient and train volunteers to support the Clubhouse programs; 2) maintain volunteer personnel records; and 3) provide annual appreciation celebration which incorporates information regarding career and training opportunities in the Behavioral Healthcare field.	

Existing Programs to be Consolidated				
No.	**Question**	**Yes**	**No**	
1.	Is this a consolidation of two or more existing programs?	☐	☒	If yes, answer question #2; If no, answer questions for existing program above
2.	Will all populations of existing program continue to be served?	☐	☐	If yes, answer question #3; If no, complete Exh. F1
3.	Will all services from existing program continue to be offered?	☐	☐	If yes, answer question #4 If no, complete Exh. F1
4.	Is the funding amount ± 15% of the sum of the previously approved amounts?	☐	☐	If yes, answer question #5 and complete Exh. E1 or E2 accordingly If no, complete Exh. F1
5.	Description of Previously Approved Programs to be consolidated. Include in your description: a) The names of Previously Approved programs to be consolidated, b) Describe the target population to be served and the services/strategies to be provided (include targeted age, gender, race/ethnicity, and language spoken by the population to be served)., and c) Provide the rationale for consolidation.			

*PEI Projects previously approved are now called Previously Approved Programs

2010/11 ANNUAL UPDATE **EXHIBIT F1**

CSS and WET NEW PROGRAM DESCRIPTION

County: El Dorado

Program Number/Name: Action #5 – Workforce Development through use of a Volunteer Program

Date: September 28, 2010

Check boxes that apply:

- ☐ CSS
- ☒ WET
- ☐ New
- ☐ Consolidation
- ☐ Expansion
- ☐ Reduction

NEW PROGRAMS ONLY

CSS and WET

1. Provide narrative description of program. For WET, also include objectives to be achieved.

This Action was formerly Action #7, and since Action #4 & #6 have been proposed for elimination, this Action has been renumbered.

Based on public feedback, the name of this Action has been changed to clarify the broad intent – this program serves to offer volunteer opportunities to the community at large – including consumers, family members, and other interested parties.

This Action addresses the priority workforce education and training need to establish a career pathway. This Action responds to the identified need to increase the workforce capacity while involving the community in a meaningful way in the delivery of services. This Action, therefore, seeks to both enhance the capacity of the Department and community to provide services and support to individuals with serious mental illness while collaborating with and accessing the use of natural community supports – community members with an interest in volunteering to serve. This type of workforce development allows the Department to provide training to those who may need an entry level place to start and to explore their interest and fit for this type of work. The MHD has an established Peer Counselor Training program that has been used successfully with volunteers, consumers and seniors and will serve as a foundation for this program. The MHD seeks to continue funding two 0.5 FTE Mental Health Aide positions with salary plus benefits to coordinate the volunteer programs.

This program is being re-submitted as a new program essentially due to our updated estimate of our costs for this fully burdened position.

Annual objectives include: 1) recruit, orient and train volunteers to support the Clubhouse programs; 2) maintain volunteer personnel records; and 3) provide annual appreciation celebration which incorporates information regarding career and training opportunities in the Behavioral Healthcare field.

2. Explain how the new program is consistent with the priorities identified in the Community Planning Process.

The WET priorities identified in the Community Planning Process were:

- Career Pathway to “grow our own”
- Staff development resources for the existing workforce to support career advancement, improved service delivery, and recruitment and retention.
- Supportive infrastructure– including a WET Coordinator to provide internship recruitment and coordination, consumer, family member and volunteer program coordination, and Regional Partnership participation.

This Action addresses the priority workforce education and training need to establish a career pathway. This Action responds to the identified need to increase the workforce capacity while involving the community in a meaningful way in the delivery of services. This Action, therefore, seeks to both enhance the capacity of the Department and community to provide services and support to individuals with serious mental illness while collaborating with and accessing the use of natural community supports – community members with an interest in volunteering to serve. This type of workforce development allows the Department to provide training and workforce involvement to those who may need an entry level place to start and to explore their interest and fit for this type of work.

CSS and WET NEW PROGRAM DESCRIPTION

3. Provide a description of how the proposed program relates to the General Standards of the MHSA (Cal. Code Regs., tit. 9, § 3320).

This Action incorporates collaboration with community members in a wellness and recovery framework and setting. The focus on the Clubhouse serves to include community members in a client-driven service delivery setting that addresses wellness and recovery. Furthermore, the WET services and resources are integrated within the CSS program setting as consumers of services may attend peer counselor training and graduate to become volunteers. Drawing from a county-wide volunteer base, we have had success in acquiring a diverse population – including bicultural and bilingual Spanish-speaking volunteers.

WET Only

1. Provide budget justification and clear outline of planning factors used to construct budgeted amount.

This program will be funded to support two part-time positions (salary plus benefits) to provide direct services in South Lake Tahoe and on the West slope of El Dorado County. In addition, the budget includes the indirect and overhead costs associated with this position: facility expenses such as rent, utilities, and janitorial services, as well as other operating expenditures such as clinical management, computing equipment and software licensing. An allowance for program-specific operational costs -- including mileage reimbursement for staff and volunteer outreach activities, funding to compensate for background checks required for potential volunteers, and food and materials to be used at recruitment and appreciation events – has been calculated as well. Total program budget, $75,305.

County: El Dorado Date: 28-Sep-10

Program/Project Name and #: WET #5 Consumer and Family Member and Volunteer Program

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. EXPENDITURES				
Community Services and Supports				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Expenditures when service provider is not known				$0
6. Non-recurring expenditures				$0
7. Other Expenditures*				$0
8. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Workforce Education and Training				
1. Personnel Expenditures	$34,998			$34,998
2. Operating Expenditures	$40,307			$40,307
3. Training Expenditures				$0
4. Training Consultant Contracts				$0
5. Residency Expenditures				$0
6. Internship Expenditures				$0
7. Mental Health Career Pathway Expenditures				$0
8. Stipend Funds				$0
9. Scholarship Funds				$0
10. Loan Repayment Funds				$0
11. Non-recurring Expenditures				$0
12. Other Expenditures*				$0
13. Total Proposed Expenditures	**$75,305**	**$0**	**$0**	**$75,305**
Capital Facilities				
1. Pre-Development Costs				$0
2. Building/Land Acquisition				$0
3. Renovation				$0
4. Construction				$0
5. Repair/Replacement Reserve				$0
6. Other Expenditures*				$0
7. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Technological Needs				
1. Personnel				$0
2. Hardware				$0
3. Software				$0
4. Contract Services				$0
5. Other Expenditures*				$0
6. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Prevention and Early Intervention (PEI)				
1. Personnel				$0
2. Operating Expenditures				$0
3. Non-recurring Expenditures				$0
4. Subcontracts/Professional Services				$0
5. Other				$0
6. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**

Innovation (INN)						
	1. Personnel					$0
	2. Operating Expenditures					$0
	3. Non-recurring Expenditures					$0
	4. Training Consultant Contracts					$0
	5. Work Plan Management					$0
	6. Other					$0
	7. Total Proposed Expenditures		**$0**	**$0**	**$0**	**$0**
B. REVENUES						
	1. New Revenues					
	a. Medi-Cal (FFP only)					$0
	b. State General Funds					$0
	c. Other Revenue					$0
	2. Total Revenues		**$0**	**$0**	**$0**	**$0**
C. TOTAL FUNDING REQUESTED			**$75,305**	**$0**	**$0**	**$75,305**

***Enter the justification for items that are requested under the "Other Expenditures" category.**

Justification:

Please include your budget narrative on a separate page.

Prepared by: Janet Stevens

Telephone Number: (530) 621-6226

WET NEW PROGRAM DESCRIPTION EXHIBIT F cont.
BUDGET NARRATIVE

Action #5 – Workforce Development through use of a Volunteer Program

This program will be funded to support two part-time Mental Health Aide positions to provide direct services in South Lake Tahoe and on the West slope of El Dorado County. In addition, the budget includes the indirect and overhead costs associated with this position: facility expenses such as rent, utilities, and janitorial services, as well as other operating expenditures such as clinical management, computing equipment and software licensing. An allowance for program-specific operational costs -- including mileage reimbursement for staff and volunteer outreach activities, funding to compensate for background checks required for potential volunteers, and food and materials to be used at recruitment and appreciation events – has been calculated as well. Total program budget, $75,305.

2010/11 ANNUAL UPDATE **EXHIBIT D1**

ELIMINATION OF PROGRAM/PROJECT

County: El Dorado

Program/Project Number/ Name: #8 Loan Assumption Programs accessible as MHPSA designee

Date: 9/28/2010

Select one:
- ☐ CSS
- ☑ WET
- ☐ CF
- ☐ TN
- ☐ PEI[1]
- ☐ INN

1. Clearly identify the program/project proposed for elimination.
Action # 8: Loan Assumption Programs accessible as MHPSA designee. This work plan addressed the Mental Health workforce shortages and diversity needs by using MHSA WET funds to create a loan assumption program through the NHSC State Loan Repayment OSHPD.
2. Describe the rationale for eliminating the program/project.
Comparable loan assumption programs are now available through other programs. In addition, only a limited number of people would able to directly benefit from the County's WET Loan Assumption project.
3. Describe how the funding for the eliminated program/project will be used.
Funding for this program will be redirected to enhancing the availability of training opportunities within the County, and extending all WET programs over the next several years.

[1] For PEI only – Counties eliminating a project with funds targeted toward Children, Youth, and Transitional-Aged Youth, the PEI Funding Request (Exhibit E4) should reflect that at least 51% of PEI funds are directed towards individuals under age 25. Small counties are exempt from this requirement. The PEI Program selected for local evaluation may not be eliminated.

County: El Dorado County Date: 28-Sep-10

	Workforce Education and Training		FY 10/11 Requested MHSA Funding	Estimated MHSA Funds by Category					
	No.	Name		Workforce Staffing Support	Training and Technical Assistance	Mental Health Career Pathway	Residency and Internship	Financial Incentive	
	Previously Approved Programs								
1.			$0			.			
2.			$0						
3.			$0						
4.			$0						
5.			$0						
6.			$0						
7.			$0						
8.			$0						
9.			$0						
10.			$0						
11.			$0						
12.			$0						
13.			$0						
14.			$0						
15.			$0						
16.	Subtotal: Previously Approved Programs		$0	$0	$0	$0	$0	$0	Percentage
17.	Plus up to 15% County Administration								#VALUE!
18.	Plus up to 10% Operating Reserve								#VALUE!
19.	Subtotal: Previously Approved Programs/County Admin./Operating Reserve		$0						
	New Programs								
1.	1	Workforce Education and Training Plan (WET) Coordinator	$101,287	$101,287					
2.	2	Workforce Development	$27,600		$27,600				
3.	3	Workforce Development through Psychiatric Rehabilitation T	$31,760			$31,760			
4.	4	Career Pathways to "Grow Our Own" Workforce: Rural Mer	$26,029			$26,029			
5.	5	Consumer and Family Member and Volunteer Program	$75,305			$75,305			
6.	Subtotal: WET New Programs		$261,981	$101,287	$27,600	$133,094	$0	$0	Percentage
7.	Plus up to 15% County Administration		$68,639						26.2%
8.	Plus up to 10% Operating Reserve		$33,062						10.0%
9.	Subtotal: New Programs/County Admin./Operating Reserve		$363,682						
10.	**Total MHSA Funds Requested**		$363,682						

Note: Previously Approved programs to be expanded, reduced, eliminated and consolidated are considered New.

2010/11 ANNUAL UPDATE **EXHIBIT D**

PREVIOUSLY APPROVED PROGRAM

County: El Dorado

Program Number/Name: Program #1 - School-based Mental Health Promotion and Service Linkage

Date: ~~September 28, 2010~~

Select one:
☐ **CSS**
☐ **WET**
☒ **PEI**
☐ **INN**

Prevention and Early Intervention				
No.	**Question**	**Yes**	**No**	
1.	Is this an existing program with no changes?	☐	☒	If yes, complete Exh. E4; If no, answer question #2
2.	Is there a change in the Priority Population or the Community Mental Health Needs?	☐	☒	If yes, completed Exh. F4; If no, answer question #3
3.	Is the current funding requested greater than15% of the previously approved amount?	☐	☒	If yes, complete Exh. F4; If no, answer question #4
4.	Is the current funding requested greater than 35% less of the previously approved amount?	☐	☒	If yes, complete Exh. F4; If no, answer questions 5, 5a, and 5b
5.	Describe the proposed changes to the Previously Approved Program and the rationale for those changes.			
This project was originally expected to serve 25 individuals/families in its initial 6 months of implementation (Jan-June 2009). During this first six months of operation, the project received fewer referrals than expected, and consequently served fewer children. A proposed name change to "Early Intervention Program for Youth" is intended to reflect an expansion of the mechanisms for referral and access. While the formerly-approved program will remain intact, access to this program will be expanded beyond the interdisciplinary screening team of MHD and school districts. The Mental Health Prevention Goal, Approach, and Age Groups will remain the same. Referrals from additional sources will be entertained. This expansion offers opportunities to increase the access and impact of this prevention and early intervention program. The budget was annualized to reflect a full year of operation (the FY 09-10 budget for six months of operation was $142,083) plus an additional 12.5% to allow for program expansion. Total budgeted amount: $319,768				
5a.	If the total number of Individuals to be served annually is different than previously reported please provide revised estimates Total Individuals: _55_ Total Families: _55__			
5b.	If the total number of clients by type of prevention annually is different than previously reported please provide revised estimates: (No change in program goals)	**Prevention**	**Early Intervention**	
	Total Individuals:		55	
	Total Families:		55	

Existing Programs to be Consolidated				
No.	**Question**	**Yes**	**No**	
1.	Is this a consolidation of two or more existing programs?	☐	☒	If yes, answer question #2; If no, answer questions for existing program above
2.	Is there a change in the Priority Population or the Community Mental Health Needs?	☐	☐	If no, answer question #3; If yes, complete Exh. F4
3.	Will the consolidated programs continue to serve the same estimated number of individuals?	☐	☐	If yes, answer question #4; If no, complete Exh. F4
4.	Description of Previously Approved Programs to be consolidated. Include in your description: a) The names of Previously Approved programs to be consolidated, b) How the Previously approved programs will be consolidated; and c) Provide the rationale for consolidation			

*PEI Projects previously approved are now called Previously Approved Programs

2010/11 ANNUAL UPDATE **EXHIBIT D**

PREVIOUSLY APPROVED PROGRAM

County: El Dorado

Program Number/Name: Program #2 - Primary Intervention Project (PIP)

Date: ~~September 28, 2010~~

Select one:
☐ **CSS**
☐ **WET**
☒ **PEI**
☐ **INN**

Prevention and Early Intervention				
No.	**Question**	**Yes**	**No**	
1.	Is this an existing program with no changes?	☒	☐	If yes, complete Exh. E4; If no, answer question #2
2.	Is there a change in the Priority Population or the Community Mental Health Needs?	☐	☒	If yes, completed Exh. F4; If no, answer question #3
3.	Is the current funding requested greater than15% of the previously approved amount?	☒	☐	If yes, complete Exh. F4; If no, answer question #4
4.	Is the current funding requested greater than 35% less of the previously approved amount?	☐	☒	If yes, complete Exh. F4; If no, answer questions 5, 5a, and 5b
5.	Describe the proposed changes to the Previously Approved Program and the rationale for those changes.			
The scope of this program will reflect a full year of operation. As such, another community (El Dorado Hills) which is isolated in reference to mental health service delivery will be integrated into this pilot program. The Mental Health Prevention Goal, Model, target population and age group remain the same. Original budgeting for this plan was $86,851 for 6 months of operation; the equivalent annualized expenditures would be $173,702. With the inclusion of the El Dorado Hills service location, program costs will increase to $237,830, representing a 37% increase in expenditures.				
5a.	If the total number of Individuals to be served annually is different than previously reported please provide revised estimates Total Individuals: 306 Total Families: _____ We expect the number of children served to increase proportionally with the addition of another community site, to a total of 306 children.			
5b.	If the total number of clients by type of prevention annually is different than previously reported please provide revised estimates:	**Prevention**		**Early Intervention**
	Total Individuals:	306		
	Total Families:			

Existing Programs to be Consolidated				
No.	**Question**	**Yes**	**No**	
1.	Is this a consolidation of two or more existing programs?	☐	☒	If yes, answer question #2; If no, answer questions for existing program above
2.	Is there a change in the Priority Population or the Community Mental Health Needs?	☐	☐	If no, answer question #3; If yes, complete Exh. F4
3.	Will the consolidated programs continue to serve the same estimated number of individuals?	☐	☐	If yes, answer question #4; If no, complete Exh. F4
4.	Description of Previously Approved Programs to be consolidated. Include in your description: a) The names of Previously Approved programs to be consolidated, b) How the Previously approved programs will be consolidated; and c) Provide the rationale for consolidation			

*PEI Projects previously approved are now called Previously Approved Programs

2010/11 ANNUAL UPDATE **EXHIBIT F4**

PEI NEW PROGRAM DESCRIPTION

County: El Dorado

Program Number/Name: Program #2 – Primary Intervention Project (PIP)

Date: September 28, 2010

Instructions: Utilizing the following format please provide responses and refer to the instructions provided in the original PEI Guidelines, as noted in DMH Information Notices No.: 07-19 and 08-23. Complete this form for each new PEI Program and existing PEI Programs that made changes to Key Community Mental Health Needs, Priority Population, and/or funding as described in the Information Notice.

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
1. Disparities in Access to Mental Health Services	☒	☐	☐	☐
2. Psycho-Social Impact of Trauma	☒	☐	☐	☐
3. At-Risk Children, Youth and Young Adult Populations	☒	☐		
4. Stigma and Discrimination	☒	☐	☐	☐
5. Suicide Risk	☒	☐	☐	☐

2. PEI Priority Population(s) **Note: All PEI programs must address underserved racial/ethnic and cultural populations.**	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
1. Trauma Exposed Individuals	☒	☐	☐	☐
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☐	☐	☐
3. Children and Youth in Stressed Families	☒	☐		
4. Children and Youth at Risk for School Failure	☒	☐		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☒	☐		
6. Underserved Cultural Populations	☒	☐	☐	☐

a. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s) and describe how the PEI program will reach/engage unserved and underserved multicultural communities.

A key feature of ensuring comprehensive and representative participation was providing a range of avenues for input and decision-making. Opportunities to participate in the Community Program Planning (CPP) process were ensured by mechanisms for information dissemination (announcements in meetings and groups attended by stakeholders, posted fliers, mass mailings, and the MHSA website providing meeting announcements, updates, and meeting minutes), education and training, outreach (comprehensive and targeted), open planning meetings, and a representative MHSA Advisory Committee. Options for anonymous input included a local phone line with a voice mailbox, an e-mail address, and use of written and online surveys. Outreach efforts included community meetings, readiness trainings, focus groups and key informant interviews which were intended to offer convenient one-time opportunities to gain information about the MHSA and to offer feedback. The detailed planning occurred in the planning and advisory committee meetings which were arenas for ongoing involvement. During Phase I, a mailing list of 390 individuals was created and over 500 survey questionnaires were completed. During Phase II, the mailing list expanded to 450 and over 185 survey questionnaires were completed.

El Dorado County's efforts to ensure a comprehensive and representative MHSA planning process included the following accomplishments during Phase I:

- 82 focus groups and readiness trainings reaching 925 respondents
- 23 key informant interviews
- 5 written surveys with a total of 545 responses
- An MHSA mailing list of 390 individuals used to send out announcements, surveys, meeting notifications, and updates.
- Local media (newspapers, cable television and radio) were used to announce community meetings and to inform the public of the MHSA planning activities and contact information.

In addition, the targeted outreach strategy that characterized Phase II ensured that we contacted the following groups via focus groups and/or use of key informant interviews:

County Mental Health Staff
Mental Health Commission Members
MHSA Program members (current consumers)
The Center for Violence-Free Relationships
NAMI members
CASA (Court Appointed Special Advocates) volunteers (TAY program)
Shingle Springs Rancheria (Native American services provider, tribe members and elders)
Youth Commission members
MORE (Mother Lode Rehabilitation Enterprises, Inc.) Disabled adults program – staff members
PFLAG (LGBT program) - volunteers
Caregivers Support Groups (various)
United Outreach (homeless services agency) - volunteers
Local Collaboratives
Headstart – Latino parents
Youth Groups (various)
Adult Drug Court Interdisciplinary Team
Teen Drug Court Representative
Juvenile Hall staff member
Alcohol and Drug Program (ADP) providers
School Nurses
School Psychologists
County Office of Education representative
Faith-based community organization members
Foster Parent Association - Representative
First 5 Commission Representative
County Office of Education – staff members
Public Guardian's Office – staff members
Early Childhood Council - Representative
Department of Human Services – staff members
School District Superintendents – staff members
County Public Health staff
Medical Library staff
County Veterans Services Office
Head Start - employees
Family Resource Centers – staff members
City Police
County Sheriff Department
County Superior Court
District Attorney's Office
Public Defender's Office
State Department of Rehabilitation
Medical Centers, Clinics, Hospitals
Council for Disabilities
Holistic Medicine Practitioners

Context:
Ensuring that the staff capacity, knowledge and skills are in place to address the County diversity issues is an ongoing challenge that is being addressed as part of the MHSA program development process. During the MHSA PEI CPP process, two MHSA Project Management Team members received training regarding use of the California Brief Multicultural Competency Scale - a diversity-training tool designed specifically for mental health practitioners with the goal of moving from cultural sensitivity to cultural competence. The goal has been to provide local Division-wide training for staff and community members over time. Implementation of this strategy, along with other strategies to address diversity of culture and language, has been significantly impacted by the Reduction in Force that took place in recent years. We have lost staff capacity related to this training, diversity, and interpretation and translation skills. Yet, the initial stage of this training process is reflected in this year's Quality Improvement Committee plan as part of the Cultural Competency sub-committee plan.

Race/Ethnicity:
The County demographics based on the 2000 Census were used during the MHSA CSS planning phase – a re-assessment pending the Census findings in 2010 will need to be conducted. To date, however, the EDC population profile is, as follows:

Race/Ethnicity:	
African American	0.7%
Asian American	2.7%
Latino	11.0%
Native American	1.4%
Caucasian	82.0%
Other	2.2%

Targeted outreach occurred where there were known groups or places where the Latino and Native American populations could be reached (English as a Second Language/ESL classes, Latino Family Resource Center, and the Rancheria). Together with the Caucasian population, this comprises 94.4% of the County population. The challenge is significant in relationship to outreach to the African American and Asian populations – together they comprise 3.4% of the County population – and we have not yet identified any particular group or setting to target for outreach purposes. It is unclear what comprises the category of "Other" but there is a growing population of Russian immigrants in the western County area closer to Sacramento. We have identified one potential contact person by which to begin to reach this population and a few of these stakeholders were represented in an outreach group.

Youth with disabilities, African American and Asian middle school students were among youth reached in the context of a special all day event which targeted youth who self-identified with a unique group or identity – typically along the lines of race/ethnicity. A MHSA team member participated in this event as a group facilitator. This event solicited their input in relationship to the exploratory question: "What is needed to help students like yourselves successfully move from middle to high school?" Issues of concerns with bullying were predominant, as was the feedback related to a need for the student voice in planning and decision-making.

Efforts to maintain feedback and dialogue with underserved populations have improved to a degree with experience and diversified MHSA service providers (Latino and Native American). The MHD is committed to continuing our efforts to improve further.

Language
Targeted outreach to the Latino population included use of bilingual/bicultural staff, focus groups at churches, ESL classes and a Latino Community Family Resource Center (FRC). In one interesting scenario, an ESL class hosted by the Latino Community FRC included a Vietnamese individual. During Phase I, extensive work was invested in getting materials translated into Spanish – including the Executive Summary of the original CSS plan. Furthermore, we had individuals at many of our key presentations available to provide interpretation for Spanish-speaking individuals. Our findings were that these resources were not utilized and that targeted outreach to small groups was a far more effective technique to engage this population in our community.

Geographic Regions
As indicated earlier, to address the separation of the Western Slope Region from South Lake Tahoe, we used teleconferencing equipment for almost all of the planning meetings. MHSA PEI training took place in person in SLT, as well, on two occasions. The Western Slope Region is expansive and beyond the County seat of Placerville, includes a community in the east (Pollock Pines), a community in the southern region (Somerset), a community to the north (Georgetown Divide), and one to the west (Cameron Park-El Dorado Hills). In addition to what is outlined below, outreach to existing community collaboratives did occur in Georgetown and El Dorado Hills. Greater efforts to identify effective ways to reach Pollock Pines and Somerset need to be made in the future.

Age Groups
Middle school, TAY, and high school students were reached via targeted outreach and/or participation in the planning meetings. There is an active EDC youth voice - they participate on their own commission (for example, giving feedback to the County regarding safety issues related to the Skate Board Park) and as full members on the El Dorado Hills Vision Coalition – and these groups were accessed as part of the MHSA PEI CPP process.

Gender and LGBT
Targeted outreach served to solicit feedback from representatives from PFLAG and agencies that serve to reduce domestic violence. The issues of personal safety and outreach to enhance access to services were important themes relevant to PEI

planning.

A strong theme that emerged from this process was the desire to intervene early on with youth from a strengths-based perspective – to build protective factors. The elementary school setting serves as both a site for both early identification and prevention intervention opportunities. It further serves to provide access to services in a non-stigmatized setting.

It is the intention of this program to better reach the un-served and under-served populations in a cost-effective manner. School-based strategies assist in accessing these communities. Each component program will be asked to have a specific plan regarding targeting and access for the underserved populations and to report on their results in the year-end progress report.

This project, **Primary Intervention Project (PIP)**, targets the PEI target population of *children and youth in stressed families* and, as such, is intended to address the community mental health needs surrounding *at-risk children*.

3. PEI Program Description (attach additional pages, if necessary).

This program is a previously approved PEI program, but we are proposing to annualize the plan (the previously approved plan was for a period of 6 months) by including one additional site. The Oak Meadow Elementary School in El Dorado Hills had previously expressed an interest in partnering with the Vision Coalition and the MHD in hosting a PIP pilot site. This site is being proposed as part of the annualized plan. El Dorado Hills is a highly populated community within the County but, as this time, does not have a mental health services site.

The Vision Coalition was formed to help youth in El Dorado Hills by providing "positive youth development" opportunities, including financial support. Youth development opportunities are activities that increase knowledge and build strength, assets, skills, and talents to help young people reach their highest potential, in ways that are safe, healthy, and free from alcohol and drug use. Funds from federal and private sector grants as well as donations from individuals and businesses in the community support the Coalition's activities.

Mental Health Prevention Goal – To decrease school adjustment difficulties at an early age and build protective factors to foster youth resilience and mental health.

Model – targeted prevention.

Age group – Youth, ages 4-9.

Determinants to be addressed:

- Determinants of conduct disorders
- Determinants of substance abuse
- Both risk and protective factors related to family conflict and aggression

Intervention Strategy/Model:
The Primary Intervention Program (PIP) Project is an evidence-based practice that has been supported by the California Department of Mental Health since 1983 and is part of the California Early Mental Health Initiative (EMHI). Staff involved in this project will plan to attend the annual EMHI training conference, which provides training in various aspects of program implementation and skills development. The PIP's goal is to increase school adjustments as school-adjustment difficulties have been linked to later delinquency, substance abuse and drop-out rates.

The program provides screening to identify children with mild aggression, withdrawal and/or learning difficulties. It is a Mental Health Promotion model with behavioral control and adaptive assertiveness among the outcomes achieved.

Provider/Location:
The PIP project is a school-based collaboration between the affected County school district and the County Mental Health Division (MHD). Teachers and a screening team identify children (K-3) who are "at risk" of developing emotional problems as indicated by their school adjustment difficulties. Alternative recommendations will be provided for youth screened out and the screening team will partner with the referring teacher and family to this end. Trained school aides provide the PIP intervention in the form of 1:1 non-directive play for approximately 30-45 minutes per week for 12-15 weeks. This proposal includes a 12-15 week skills training group intervention strategy at some sites called "Second Step" – a violence prevention program which is also a part of the California Early Mental Health Initiative.

The PIP Program will:

- Serve students in kindergarten through third grade in public schools experiencing mild to moderate school adjustment difficulties. The services are school-based and low cost. Supervised and trained child aides provide weekly play sessions with the selected students.
- Ensure that students are selected for program participation through a systematic selection process that includes completion of standardized assessments and input from the school-based mental health professional and teachers.
- Encourage the involvement of parents/guardians and teaching staff to build alliances to promote student's mental health and social and emotional development. Parental consent is required for student participation.
- Have a core team consisting of school-based, credentialed mental health professionals, local mental health professionals (from a cooperating mental health entity) and child aides.
- Ensure that credentialed school-based mental health professionals provide ongoing supervision/training of child aides.
- Provide ongoing monitoring and evaluation of program services.

Three school districts (seven school sites) will provide the appropriate space for this project, an MHSA-funded, school-employed mental health professional who will participate in the screening and training sessions, and a coordinator to manage the collection and submission of program data. The intention is to ensure that this program is available in three regions of the County (the communities of South Lake Tahoe, the Georgetown Divide and El Dorado Hills) for a pilot of up to two years. This approach provides an opportunity to use MHSA funds to incubate efforts as the funds are not sufficient to provide for County-wide programs. The continued use of this model and the locations for use of these funds will be re-evaluated continuously as the community engages in ongoing MHSA PEI planning.

4. Activities

Activity Title	Proposed number of individuals or families through PEI expansion to be served through June 2011 by type of prevention:			Number of months in operation through June 2011
		Prevention	Early Intervention	
Primary Intervention Project (PIP)	Individuals: Families:	306		12
Total PEI Program Estimated Unduplicated Count of Individuals to be Served	Individuals: Families:	306		

5. Describe how the program links PEI participants to County Mental Health and providers of other needed services

PIP and Second Step Child Aides will be trained regarding referral and access to County Mental Health Services, including the Early Intervention for Youth Program and services for adults. Linkage to other needed services may be improved as a function of the agencies participation in the local Community Strengthening Groups in which collaboration with other providers is enhanced.

6. Describe collaboration with and system enhancements of other partners such as community based organizations, schools, and primary care.

This strategy involves community collaboratives, a mental health – school district collaboration, an interdisciplinary team screening process, and enhances mental health service access. As such, it represents a key system enhancement related to health promotion and the enhancement of protective factors that target areas of concern in EDC (family stress and the youth delinquency).

7. Describe intended outcomes.

The fundamental goals are to:

- Provide prevention and early intervention services at a young age.
- Provide services in a school-based setting to enhance access.
- Build protective factors by facilitating successful school adjustment.
- Target violence prevention as a function of a skills training.

8. Describe coordination with Other MHSA Components.

The MHSA CSS programs will be accessed through the Early Intervention for Youth Program clinicians proposed under Program #1 as the need arises – this may include the need for adult services. The WET Coordinator will be looking for opportunities to merge workforce development and the need for capacity building in the arena of prevention and health promotions in collaboration with the MHSA Project Coordinator.

The other MHSA components are still under development.

9. Provide a budget narrative for costs identified for this Program, as outlined in Exhibit F. Please include the number of FTE personnel positions/classifications and a brief description of each FTE's functions. Please include a brief description of operating costs, subcontracts/professional services, and non-recurring

expenditures associated with this PEI Program.

With the exception of the subcontracted costs associated with the addition of a new project location, there are few changes to the budget for this project.

Personnel costs totaling $48,422 provide for:

- 1.4 FTE Mental Health Aides who will provide weekly play sessions with selected students
- 0.1 FTE Mental Health Program Coordinator who will provide ongoing professional supervision, coordinate program activities, liaison with school personnel, and participate in the screening process.

Ongoing operating expenditures totaling $61,408 include the following:

- Program materials and toys, $2,100
- Transportation and mileage to school sites, $1,000
- Required staff training and the travel costs associated participation in the annual EMHI training conference, which is held in Southern California, $3,210
- Facility, overhead and indirect costs associated with program planning and implementation, $55,098

Subcontracted locations/services:

- El Dorado County Department of Education, $84, 000: contract to provide PIP services at two locations within the Georgetown Divide region of the County;
- Vision Coalition, $42,000: contract to provide PIP services at Oak Meadow Elementary School in El Dorado Hills.

Total program budget: 237,830

10. Additional Comments (Optional)

None.

County: El Dorado Date: 28-Sep-10

Program/Project Name and #: PEI #2 Primary Intervention Project (PIP)

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. EXPENDITURES				
Community Services and Supports				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Expenditures when service provider is not known				$0
6. Non-recurring expenditures				$0
7. Other Expenditures*				$0
8. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Workforce Education and Training				
1. Personnel Expenditures				$0
2. Operating Expenditures				$0
3. Training Expenditures				$0
4. Training Consultant Contracts				$0
5. Residency Expenditures				$0
6. Internship Expenditures				$0
7. Mental Health Career Pathway Expenditures				$0
8. Stipend Funds				$0
9. Scholarship Funds				$0
10. Loan Repayment Funds				$0
11. Non-recurring Expenditures				$0
12. Other Expenditures*				$0
13. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Capital Facilities				
1. Pre-Development Costs				$0
2. Building/Land Acquisition				$0
3. Renovation				$0
4. Construction				$0
5. Repair/Replacement Reserve				$0
6. Other Expenditures*				$0
7. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Technological Needs				
1. Personnel				$0
2. Hardware				$0
3. Software				$0
4. Contract Services				$0
5. Other Expenditures*				$0
6. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Prevention and Early Intervention (PEI)				
1. Personnel	$48,422	$84,000	$42,000	$174,422
2. Operating Expenditures	$61,408			$61,408
3. Non-recurring Expenditures				$0
4. Subcontracts/Professional Services			$2,000	$2,000
5. Other				$0
6. Total Proposed Expenditures	**$109,830**	**$84,000**	**$44,000**	**$237,830**

Innovation (INN)						
	1. Personnel					$0
	2. Operating Expenditures					$0
	3. Non-recurring Expenditures					$0
	4. Training Consultant Contracts					$0
	5. Work Plan Management					$0
	6. Other					$0
	7. Total Proposed Expenditures		**$0**	**$0**	**$0**	**$0**
B. REVENUES						
	1. New Revenues					
	a. Medi-Cal (FFP only)					$0
	b. State General Funds					$0
	c. Other Revenue					$0
	2. Total Revenues		**$0**	**$0**	**$0**	**$0**
C. TOTAL FUNDING REQUESTED			**$109,830**	**$84,000**	**$44,000**	**$237,830**

***Enter the justification for items that are requested under the "Other Expenditures" category.**

Justification:

Please include your budget narrative on a separate page.

Prepared by: Janet Stevens

Telephone Number: (530) 621-6226

PEI NEW PROGRAM DESCRIPTION EXHIBIT F cont.
BUDGET NARRATIVE

Action #2 – Primary Intervention Project

With the exception of the subcontracted costs associated with the addition of a new project location, there are few changes to the budget for this project.

Personnel costs totaling $48,422 provide for:

- 1.4 FTE Mental Health Aides who will provide weekly play sessions with selected students
- 0.1 FTE Mental Health Program Coordinator who will provide ongoing professional supervision, coordinate program activities, liaison with school personnel, and participate in the screening process.

Ongoing operating expenditures totaling $61,408 include the following:

- Program materials and toys, $2,100
- Transportation and mileage to school sites, $1,000
- Required staff training and the travel costs associated participation in the annual EMHI training conference, which is held in Southern California, $3,210
- Facility, overhead and indirect costs associated with program planning and implementation, $55,098

Subcontracted locations/services:

- El Dorado County Department of Education, $84, 000: contract to provide PIP services at two locations within the Georgetown Divide region of the County;
- Vision Coalition, $42,000: contract to provide PIP services at Oak Meadow Elementary School in El Dorado Hills.

Total program budget: $237,830

2010/11 ANNUAL UPDATE **EXHIBIT D**

PREVIOUSLY APPROVED PROGRAM

County: El Dorado

Program Number/Name: Program #3 - Incredible Years

Date: ~~September 28, 2010~~

Select one:

☐ **CSS**
☐ **WET**
☒ **PEI**
☐ **INN**

Prevention and Early Intervention				
No.	**Question**	**Yes**	**No**	
1.	Is this an existing program with no changes?	☐	☒	If yes, complete Exh. E4; If no, answer question #2
2.	Is there a change in the Priority Population or the Community Mental Health Needs?	☐	☒	If yes, completed Exh. F4; If no, answer question #3
3.	Is the current funding requested greater than15% of the previously approved amount?	☒	☐	If yes, complete Exh. F4; If no, answer question #4
4.	Is the current funding requested greater than 35% less of the previously approved amount?	☐	☒	If yes, complete Exh. F4; If no, answer questions 5, 5a, and 5b
5.	Describe the proposed changes to the Previously Approved Program and the rationale for those changes.			
The scope of this program will now reflect a full year of operation. As such, additional classes will be offered in various settings. Furthermore, the County plans to offer an Incredible Years (IY) training seminar to expand the capacity of Mental Health staff to conduct IY classes in the local community. The budget of the Incredible Years program has been increased to reflect the costs of additional class offerings at new locations, and to include operational costs for professional services for training, educational materials, travel, and staff time (salary and benefits). The Mental Health Prevention Goal, Model, target population and age group remain the same. The FY 09/10 budget for 6 months of operation was $21,360 (equivalent to $42,720 annually). The current request for $157,777 reflects an annualized program, with an expansion of program locations and the addition of training/education for additional staff trainers.				
5a.	If the total number of Individuals to be served annually is different than previously reported please provide revised estimates Total Individuals: ___282__ Total Families: 94			
5b.	If the total number of clients by type of prevention annually is different than previously reported please provide revised estimates:	**Prevention**		**Early Intervention**
	Total Individuals:	282		
	Total Families:	94		

Existing Programs to be Consolidated				
No.	**Question**	**Yes**	**No**	
1.	Is this a consolidation of two or more existing programs?	☐	☒	If yes, answer question #2; If no, answer questions for existing program above
2.	Is there a change in the Priority Population or the Community Mental Health Needs?	☐	☐	If no, answer question #3; If yes, complete Exh. F4
3.	Will the consolidated programs continue to serve the same estimated number of individuals?	☐	☐	If yes, answer question #4; If no, complete Exh. F4
4.	Description of Previously Approved Programs to be consolidated. Include in your description: a) The names of Previously Approved programs to be consolidated, b) How the Previously approved programs will be consolidated; and c) Provide the rationale for consolidation			

*PEI Projects previously approved are now called Previously Approved Programs

2010/11 ANNUAL UPDATE **EXHIBIT F4**

PEI NEW PROGRAM DESCRIPTION

County: El Dorado

Program Number/Name: Program #3 – Incredible Years (IY)

Date: September 28, 2010

Instructions: Utilizing the following format please provide responses and refer to the instructions provided in the original PEI Guidelines, as noted in DMH Information Notices No.: 07-19 and 08-23. Complete this form for each new PEI Program and existing PEI Programs that made changes to Key Community Mental Health Needs, Priority Population, and/or funding as described in the Information Notice.

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
1. Disparities in Access to Mental Health Services	☒	☐	☒	☐
2. Psycho-Social Impact of Trauma	☒	☐	☒	☐
3. At-Risk Children, Youth and Young Adult Populations	☒	☐		
4. Stigma and Discrimination	☒	☐	☒	☐
5. Suicide Risk	☒	☐	☒	☐

2. PEI Priority Population(s) **Note: All PEI programs must address underserved racial/ethnic and cultural populations.**	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
1. Trauma Exposed Individuals	☒	☐	☒	☐
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☒	☐	☒	☐
3. Children and Youth in Stressed Families	☒	☐		
4. Children and Youth at Risk for School Failure	☒	☐		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☒	☐		
6. Underserved Cultural Populations	☒	☐	☒	☐

a. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s) and describe how the PEI program will reach/engage unserved and underserved multicultural communities.

A key feature of ensuring comprehensive and representative participation was providing a range of avenues for input and decision-making. Opportunities to participate in the Community Program Planning (CPP) process were ensured by mechanisms for information dissemination (announcements in meetings and groups attended by stakeholders, posted fliers, mass mailings, and the MHSA website providing meeting announcements, updates, and meeting minutes), education and training, outreach (comprehensive and targeted), open planning meetings, and a representative MHSA Advisory Committee. Options for anonymous input included a local phone line with a voice mailbox, an e-mail address, and use of written and online surveys. Outreach efforts included community meetings, readiness trainings, focus groups and key informant interviews which were intended to offer convenient one-time opportunities to gain information about the MHSA and to offer feedback. The detailed planning occurred in the planning and advisory committee meetings which were arenas for ongoing involvement. During Phase I, a mailing list of 390 individuals was created and over 500 survey questionnaires were completed. During Phase II, the mailing list expanded to 450 and over 185 survey questionnaires were completed.

El Dorado County's efforts to ensure a comprehensive and representative MHSA planning process included the following accomplishments during Phase I:

- 82 focus groups and readiness trainings reaching 925 respondents
- 23 key informant interviews
- 5 written surveys with a total of 545 responses
- An MHSA mailing list of 390 individuals used to send out announcements, surveys, meeting notifications, and updates.
- Local media (newspapers, cable television and radio) were used to announce community meetings and to inform the public of the MHSA planning activities and contact information.

In addition, the targeted outreach strategy that characterized Phase II ensured that we contacted the following groups via focus groups and/or use of key informant interviews:

County Mental Health Staff
Mental Health Commission Members
MHSA Program members (current consumers)
Center for Violence-Free Relationships
NAMI members
CASA (Court Appointed Special Advocates) volunteers (TAY program)
Shingle Springs Rancheria (Native American services provider, tribe members and elders)
Youth Commission members
MORE (Mother Lode Rehabilitation Enterprises, Inc.) Disabled adults program – staff members
PFLAG (LGBT program) - volunteers
Caregivers Support Groups (various)
United Outreach (homeless services agency) - volunteers
Local Collaboratives
Headstart – Latino parents
Youth Groups (various)
Adult Drug Court Interdisciplinary Team
Teen Drug Court Representative
Juvenile Hall staff member
Alcohol and Drug Program (ADP) providers
School Nurses
School Psychologists
County Office of Education representative
Faith-based community organization members
Foster Parent Association - Representative
First 5 Commission Representative
County Office of Education – staff members
Public Guardian's Office – staff members
Early Childhood Council - Representative
Department of Human Services – staff members
School District Superintendents – staff members
County Public Health staff
Medical Library staff
County Veterans Services Office
Head Start - employees
Family Resource Centers – staff members
City Police
County Sheriff Department
County Superior Court
District Attorney's Office
Public Defender's Office
State Department of Rehabilitation
Medical Centers, Clinics, Hospitals
Council for Disabilities
Holistic Medicine Practitioners

Context:
Ensuring that the staff capacity, knowledge and skills are in place to address the County diversity issues is an ongoing challenge that is being addressed as part of the MHSA program development process. During the MHSA PEI CPP process, two MHSA Project Management Team members received training regarding use of the California Brief Multicultural Competency Scale - a diversity-training tool designed specifically for mental health practitioners with the goal of moving from cultural sensitivity to cultural competence. The goal has been to provide local Division-wide training for staff and community members over time. Implementation of this strategy, along with other strategies to address diversity of culture and language, have been significantly impacted by the Reduction in Force that took in recent years. We have lost staff capacity related to this training, diversity, and interpretation and translation skills. Yet, the initial stage of this training process is reflected in this year's Quality Improvement Committee plan as part of the Cultural Competency sub-committee plan.

Race/Ethnicity:
The County demographics based on the 2000 Census were used during the MHSA CSS planning phase – a re-assessment pending the Census findings in 2010 will need to be conducted. To date, however, the EDC population profile is, as follows:

Race/Ethnicity:	
African American	0.7%
Asian American	2.7%
Latino	11.0%
Native American	1.4%
Caucasian	82.0%
Other	2.2%

Targeted outreach occurred where there were known groups or places where the Latino and Native American populations could be reached (English as a Second Language/ESL classes, Latino Family Resource Center, and the Rancheria). Together with the Caucasian population, this comprises 94.4% of the County population. The challenge is significant in relationship to outreach to the African American and Asian populations – together they comprise 3.4% of the County population – and we have not yet identified any particular group or setting to target for outreach purposes. It is unclear what comprises the category of "Other" but there is a growing population of Russian immigrants in the western County area closer to Sacramento. We have identified one potential contact person by which to begin to reach this population and a few of these stakeholders were represented in an outreach group.

Youth with disabilities, African American and Asian middle school students were among youth reached in the context of a special all day event which targeted youth who self-identified with a unique group or identity – typically along the lines of race/ethnicity. A MHSA team member participated in this event as a group facilitator. This event solicited their input in relationship to the exploratory question: "What is needed to help students like yourselves successfully move from middle to high school?" Issues of concerns with bullying were predominant, as was the feedback related to a need for the student voice in planning and decision-making.

Efforts to maintain feedback and dialogue with underserved populations have improved to a degree with experience and diversified MHSA service providers (Latino and Native American). The MHD is committed to continuing our efforts to improve further.

Language
Targeted outreach to the Latino population included use of bilingual/bicultural staff, focus groups at churches, ESL classes and a Latino Community Family Resource Center (FRC). In one interesting scenario, an ESL class hosted by the Latino Community FRC included a Vietnamese individual. During Phase I, extensive work was invested in getting materials translated into Spanish – including the Executive Summary of the original CSS plan. Furthermore, we had individuals at many of our key presentations available to provide interpretation for Spanish-speaking individuals. Our findings were that these resources were not utilized and that targeted outreach to small groups was a far more effective technique to engage this population in our community.

Geographic Regions
As indicated earlier, to address the separation of the Western Slope Region from South Lake Tahoe, we used teleconferencing equipment for almost all of the planning meetings. MHSA PEI training took place in person in SLT, as well, on two occasions. The Western Slope Region is expansive and beyond the County seat of Placerville, includes a community in the east (Pollock Pines), a community in the southern region (Somerset), a community to the north (Georgetown Divide), and one to the west (Cameron Park-El Dorado Hills). In addition to what is outlined below, outreach to existing community collaboratives did occur in Georgetown and El Dorado Hills. Greater efforts to identify effective ways to reach Pollock Pines and Somerset need to be made in the future.

Age Groups
Middle school, TAY, and high school students were reached via targeted outreach and/or participation in the planning meetings. There is an active EDC youth voice - they participate on their own commission (for example, giving feedback to the County regarding safety issues related to the Skate Board Park) and as full members on the El Dorado Hills Vision Coalition – and these groups were accessed as part of the MHSA PEI CPP process.

Gender and LGBT
Targeted outreach served to solicit feedback from representatives of PFLAG and agencies that serve to address domestic violence. The issues of personal safety and outreach to enhance access to services were important themes relevant to PEI

planning.

Through this process, the desire to expand a highly successful existing program (indicated) in a universal and selective approach, was expressed. Another facet of the expansion strategy was to "bring it on the road" to provide parenting classes in community-based (vs clinic-based) settings. Parenting classes as a family-strengthening approach for both prevention and early intervention purposes is viewed as highly effective and valued. PEI funding is, therefore, proposed for use when the classes are targeting *universal and selective* populations – both in clinics and in the community.

It is the intention of this program to better reach the un-served and under-served populations in a cost-effective manner. The movement toward community-based sites for this program enhances visibility and access to these services for previously un-served populations. Use of bilingual and bicultural and partners will continue to be pursued to further assist in better serving under-served communities. Each component program will be asked to have a specific plan regarding targeting and access for the underserved populations and to report on their results in the year-end progress report.

3. PEI Program Description (attach additional pages, if necessary).

This program was previously approved in January 2010 for a 6 month plan. Therefore, it is currently being annualized to provide 6 classes for the universal and selective populations. In addition, the ongoing need to expand the capacity of trainers will be addressed by pursuing training for new class facilitators.

Mental Health Prevention Goal – To promote emotional and social competence and prevent behavioral and emotional problems in young children by impacting multiple risk and protective factors that impact the development of conduct problems.

Approach – universal and selective prevention.

Age group – Youth, 2 - 12.

Determinants to be addressed:

- Determinants of conduct disorders
- Determinants of other common mental health concerns such as depression and anxiety
- Determinants of substance abuse
- Both risk and protective factors related to family conflict and aggression

The protective factors that will be addressed include bonding, opportunities, recognition and skills.

The risk factors that will be addressed include early and persistent antisocial behavior, family conflict, family management problems, favorable parental attitudes and involvement in problem behaviors, and lack of commitment to school.

Intervention Strategy/Model:
The **Incredible Years Program** is a set of comprehensive, multi-faceted, and developmentally-based curricula targeting 2-12 year old children, their parents, and school teachers. This strategy addresses the role of multiple interacting risk and protective factors in the development of conduct disorders. This intervention strategy thereby serves as a violence prevention strategy. Each program component is designed to work interactively with the others to promote emotional and social competence and prevent, reduce and treat behavioral and emotional problems in young children. This is a 12-14 week program with an estimated cost per un-insured family of $1000.

Provider/Location:
The County Mental Health staff will provide classroom facilitators and seek to work with community and/or school agencies to provide the space and PEI-funded childcare, meals and operational materials.

As a mental health promotion strategy, the goal is to bring this program to various community settings approximately six times this year in order to make this effective program available to stressed families County-wide. These classes are envisioned as providing opportunities to bring this program, one series at a time, to the outer-lying communities. The determination of the specific sites for these services is still under evaluation but the goal is to ensure some capacity for bilingual/bicultural services for the Latino community.

The host site will advertise the class series and will register clients. Along with the host site, the Mental Health clinician, other MHD personnel, and potentially school personnel will provide referrals and complete a pre-screening form with the family in the event that priority decisions need to be made for applicants. A representative from the host site will partner

with the assigned class facilitators to serve as a screening committee. Alternative recommendations will be provided for families screened out and the screening team will partner with the family to this end.

4. Activities

Activity Title	Proposed number of individuals or families through PEI expansion to be served through June 2011 by type of prevention:			Number of months in operation through June 2011
		Prevention	Early Intervention	
Incredible Years (IY)	Individuals: Families:	282 94		12
Total PEI Program Estimated Unduplicated Count of Individuals to be Served	Individuals: Families:	282 94		

5. Describe how the program links PEI participants to County Mental Health and providers of other needed services

The interdisciplinary screening team proposed under Program #1 comprised of Mental Health and County Office of Education personnel will serve as a key referral source to this program and the participating Mental Health clinicians (Program #1) will be charged with providing linkage to services for children and families in need. The Mental Health clinicians will receive training related to the available mental health services – including other MHSA services and services for adults – in order to ensure effective service brokerage. The clinicians' participation in the Community Strengthening Groups will also facilitate enhanced access to a range of services. Client participation in this program will serve to break down barriers, reduce stigma, and increase access to mental health and other services. The availability of this program will be marketed to community partners by the host sites.

6. Describe collaboration with and system enhancements of other partners such as community based organizations, schools, and primary care.

This program will be executed in collaboration with the County Office of Education and local community collaboratives and represents a systems enhancement in the form of increased school and community-based prevention services. Furthermore, this program builds on the current success of the MHSA CSS-funded Incredible Years classes which have been limited to families involved in the Specialty Mental Health level of treatment. Enhanced access for families (at the stage of PEI and including Medi-Cal and non-Medi-Cal families) is intended with this PEI program.

7. Describe intended outcomes.

The fundamental goals are to increase:

- Positive and nurturing parents
- Child positive behaviors, social competence, and school readiness skills
- Parent bonding and involvement with teachers/school
- Teacher classroom management skills

The goals also are to decrease:

- Harsh, coercive and negative parenting
- Children behavior problems

The Youth Outcome Questionnaire (YOQ) will be applied on a pre and post class basis.

8. Describe coordination with Other MHSA Components.

Coordination with the MHSA CSS program staff will be critical to ensure effective leveraging of the staff trained in this intervention strategy. Information regarding the availability of this program will be provided to MHSA CSS and WET program staff and participants as potential sources of referrals.

The WET Coordinator will be looking for opportunities to merge workforce development and the need for capacity building in the arena of prevention and health promotions in collaboration with the MHSA Project Coordinator.

The other MHSA components are still under development.

PEI NEW PROGRAM DESCRIPTION

9. Provide a budget narrative for costs identified for this Program, as outlined in Exhibit F. Please include the number of FTE personnel positions/classifications and a brief description of each FTE's functions. Please include a brief description of operating costs, subcontracts/professional services, and non-recurring expenditures associated with this PEI Program.

Budgeting for this program reflects the costs of additional class offerings at new locations, and includes operational costs for professional services for training, educational materials, travel, and staff time (salary and benefits). The FY 09/10 budget for 6 months of operation was $21,360 (equivalent to $42,720 annually). The current request for $155,777 reflects an annualized program and the addition of training/education for additional staff trainers.

- The personnel costs (salary, benefits and taxes) for presenting the Incredible Years workshops in six community-based settings total $48,168, based on the following:
  - Mental Health Clinician: Approximately 14 hours/week for 12 weeks, each session. With six sessions planned, this totals 1008 hours, or 0.5 FTE
- Additional personnel costs for IY training (six Mental Health Clinicians and two Mental Health Workers, each for 8 hours/day for three days): $7,703
- Operational Costs for the presentation of the six community IY sessions and training for eight MH staff include the following:
  - Facility, Indirect and Overhead costs facility expenses such as rent, utilities, and janitorial services, as well as other operating expenditures such as clinical management, computing equipment and software licensing: $59,406
  - Role Play toys: $500
  - Child activity materials and food: $12,400
  - Parent books, materials, and door prizes: $6,600
  - Transportation (mileage) for clinicians to conduct community-based workshops: $2500
- One-Time, non-recurring expenditures:
  - Purchase of Incredible Years curriculum for older children/adolescents: $2,000
- Subcontracts/Professional Services:
  - Use of the South Lake Tahoe Tot Spot, including site supervision and the cost to provide an additional Child Care Worker, $1,500
  - Vision Coalition contract services for IY workshops in El Dorado Hills: $10,000
  - Incredible Years professional trainer time and expenses: $5,000

10. Additional Comments (Optional)

None.

County: El Dorado Date: 28-Sep-10

Program/Project Name and #: PEI #3 Incredible Years

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. EXPENDITURES				
Community Services and Supports				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Expenditures when service provider is not known				$0
6. Non-recurring expenditures				$0
7. Other Expenditures*				$0
8. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Workforce Education and Training				
1. Personnel Expenditures				$0
2. Operating Expenditures				$0
3. Training Expenditures				$0
4. Training Consultant Contracts				$0
5. Residency Expenditures				$0
6. Internship Expenditures				$0
7. Mental Health Career Pathway Expenditures				$0
8. Stipend Funds				$0
9. Scholarship Funds				$0
10. Loan Repayment Funds				$0
11. Non-recurring Expenditures				$0
12. Other Expenditures*				$0
13. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Capital Facilities				
1. Pre-Development Costs				$0
2. Building/Land Acquisition				$0
3. Renovation				$0
4. Construction				$0
5. Repair/Replacement Reserve				$0
6. Other Expenditures*				$0
7. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Technological Needs				
1. Personnel				$0
2. Hardware				$0
3. Software				$0
4. Contract Services				$0
5. Other Expenditures*				$0
6. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Prevention and Early Intervention (PEI)				
1. Personnel	$55,871		$10,300	$66,171
2. Operating Expenditures	$81,406		$1,200	$82,606
3. Non-recurring Expenditures	$2,000			$2,000
4. Subcontracts/Professional Services			$5,000	$5,000
5. Other				$0
6. Total Proposed Expenditures	**$139,277**	**$0**	**$16,500**	**$155,777**

Innovation (INN)						
	1. Personnel					$0
	2. Operating Expenditures					$0
	3. Non-recurring Expenditures					$0
	4. Training Consultant Contracts					$0
	5. Work Plan Management					$0
	6. Other					$0
	7. Total Proposed Expenditures		**$0**	**$0**	**$0**	**$0**
B. REVENUES						
	1. New Revenues					
	a. Medi-Cal (FFP only)					$0
	b. State General Funds					$0
	c. Other Revenue					$0
	2. Total Revenues		**$0**	**$0**	**$0**	**$0**
C. TOTAL FUNDING REQUESTED			**$139,277**	**$0**	**$16,500**	**$155,777**

***Enter the justification for items that are requested under the "Other Expenditures" category.**

Justification:

Please include your budget narrative on a separate page.

Prepared by: Janet Stevens

Telephone Number: (530) 621-6226

PEI NEW PROGRAM DESCRIPTION EXHIBIT F cont.
BUDGET NARRATIVE

Action #3 – Incredible Years

Budgeting for this program reflects the costs of additional class offerings at new locations, and includes operational costs for professional services for training, educational materials, travel, and staff time (salary and benefits). The FY 09/10 budget for 6 months of operation was $21,360 (equivalent to $42,720 annually). The current request for $155,777 reflects an annualized program and the addition of training/education for additional staff trainers.

- The personnel costs (salary, benefits and taxes) for presenting the Incredible Years workshops in six community-based settings total $48,168, based on the following:
  - Mental Health Clinician: Approximately 14 hours/week for 12 weeks, each session. With six sessions planned, this totals 1008 hours, or 0.5 FTE
- Additional personnel costs for IY training (six Mental Health Clinicians and two Mental Health Workers, each for 8 hours/day for three days): $7,703
- Operational Costs for the presentation of the six community IY sessions and training for eight MH staff include the following:
  - Facility, Indirect and Overhead costs facility expenses such as rent, utilities, and janitorial services, as well as other operating expenditures such as clinical management, computing equipment and software licensing: $59,406
  - Role Play toys: $500
  - Child activity materials and food: $12,400
  - Parent books, materials, and door prizes: $6,600
  - Transportation (mileage) for clinicians to conduct community-based workshops: $2500
- One-Time, non-recurring expenditures:
  - Purchase of Incredible Years curriculum for older children/adolescents: $2,000
- Subcontracts/Professional Services:
  - Use of the South Lake Tahoe Tot Spot, including site supervision and the cost to provide an additional Child Care Worker, $1,500
  -Vision Coalition contract services for IY workshops in El Dorado Hills: $10,000
  - Incredible Years professional trainer time and expenses: $5,000

2010/11 ANNUAL UPDATE **EXHIBIT D**

PREVIOUSLY APPROVED PROGRAM

County: El Dorado

Program Number/Name: Program #4 - Community Education Project

Date: September 28, 2010

Select one:
☐ **CSS**
☐ **WET**
☒ **PEI**
☐ **INN**

Prevention and Early Intervention				
No.	**Question**	**Yes**	**No**	
1.	Is this an existing program with no changes?	☐	☒	If yes, complete Exh. E4; If no, answer question #2
2.	Is there a change in the Priority Population or the Community Mental Health Needs?	☒	☐	If yes, completed Exh. F4; If no, answer question #3
3.	Is the current funding requested greater than15% of the previously approved amount?	☒	☐	If yes, complete Exh. F4; If no, answer question #4
4.	Is the current funding requested greater than 35% less of the previously approved amount?	☐	☒	If yes, complete Exh. F4; If no, answer questions 5, 5a, and 5b
5.	Describe the proposed changes to the Previously Approved Program and the rationale for those changes.			
The proposed change to this program is designed to expand the scope and diversify the PEI strategies available to the community. Feedback received from the community indicated that an increased investment in educational prevention strategies was desirable as a cost-effective, pro-active measure. The Parenting Wisely scope will be expanded from the proposed 6 month scope to an annualized plan to allow resources to be purchased for use in various community settings. NAMI has requested training to diversity the types of classes that they can provide to the local community. PFLAG will broaden its target audience to network with various community-based service organizations and diversify its library of educational materials. Under this amended program, a Community Access Site (CAS) or web-based community education and information resource center for consumers of mental health services, family members and community stakeholders will be initiated, as well. This community referral site will provide free access to a comprehensive library of interactive online courses targeting the general public. Finally, this program will include a Consumer Leadership Academy providing educational opportunities designed to inform and empower consumers to facilitate meaningful participation in the broader community. To facilitate client and community involvement, funding and the establishment of a stipend program to address costs incurred for participants will be pursued. Total program budget: $69,109				
5a.	If the total number of Individuals to be served annually is different than previously reported please provide revised estimates Total Individuals: __230__ Total Families: __55__			
5b.	If the total number of clients by type of prevention annually is different than previously reported please provide revised estimates:	**Prevention**	**Early Intervention**	
	Total Individuals:	230		
	Total Families:	55		

Existing Programs to be Consolidated				
No.	**Question**	**Yes**	**No**	
1.	Is this a consolidation of two or more existing programs?	☐	☒	If yes, answer question #2; If no, answer questions for existing program above
2.	Is there a change in the Priority Population or the Community Mental Health Needs?	☐	☐	If no, answer question #3; If yes, complete Exh. F4
3.	Will the consolidated programs continue to serve the same estimated number of individuals?	☐	☐	If yes, answer question #4; If no, complete Exh. F4
4.	Description of Previously Approved Programs to be consolidated. Include in your description: a) The names of Previously Approved programs to be consolidated, b) How the Previously approved programs will be consolidated; and			

*PEI Projects previously approved are now called Previously Approved Programs

	c) Provide the rationale for consolidation

*PEI Projects previously approved are now called Previously Approved Programs

2010/11 ANNUAL UPDATE **EXHIBIT F4**

PEI NEW PROGRAM DESCRIPTION

County: El Dorado

Program Number/Name: Program #4 – Community Education Project

Date: September 28, 2010

Instructions: Utilizing the following format please provide responses and refer to the instructions provided in the original PEI Guidelines, as noted in DMH Information Notices No.: 07-19 and 08-23. Complete this form for each new PEI Program and existing PEI Programs that made changes to Key Community Mental Health Needs, Priority Population, and/or funding as described in the Information Notice.

1. PEI Key Community Mental Health Needs	**Age Group**			
	Children and Youth	**Transition-Age Youth**	**Adult**	**Older Adult**
1. Disparities in Access to Mental Health Services	☒	☒	☒	☒
2. Psycho-Social Impact of Trauma	☒	☒	☒	☒
3. At-Risk Children, Youth and Young Adult Populations	☒	☒		
4. Stigma and Discrimination	☒	☒	☒	☒
5. Suicide Risk	☒	☒	☒	☒

2. PEI Priority Population(s) **Note: All PEI programs must address underserved racial/ethnic and cultural populations.**	**Age Group**			
	Children and Youth	**Transition-Age Youth**	**Adult**	**Older Adult**
1. Trauma Exposed Individuals	☒	☒	☒	☒
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☒	☒	☒	☒
3. Children and Youth in Stressed Families	☒	☒		
4. Children and Youth at Risk for School Failure	☒	☒		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☒	☒		
6. Underserved Cultural Populations	☒	☒	☒	☒

a. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s) and describe how the PEI program will reach/engage unserved and underserved multicultural communities.

A key feature of ensuring comprehensive and representative participation was providing a range of avenues for input and decision-making. Opportunities to participate in the Community Program Planning (CPP) process were ensured by mechanisms for information dissemination (announcements in meetings and groups attended by stakeholders, posted fliers, mass mailings, and the MHSA website providing meeting announcements, updates, and meeting minutes), education and training, outreach (comprehensive and targeted), open planning meetings, and a representative MHSA Advisory Committee. Options for anonymous input included a local phone line with a voice mailbox, an e-mail address, and use of written and online surveys. Outreach efforts included community meetings, readiness trainings, focus groups and key informant interviews which were intended to offer convenient one-time opportunities to gain information about the MHSA and to offer feedback. The detailed planning occurred in the planning and advisory committee meetings which were arenas for ongoing involvement. During Phase I, a mailing list of 390 individuals was created and over 500 survey questionnaires were completed. During Phase II, the mailing list expanded to 450 and over 185 survey questionnaires were completed.

El Dorado County's efforts to ensure a comprehensive and representative MHSA planning process included the following accomplishments during Phase I:

- 82 focus groups and readiness trainings reaching 925 respondents
- 23 key informant interviews
- 5 written surveys with a total of 545 responses
- An MHSA mailing list of 390 individuals used to send out announcements, surveys, meeting notifications, and updates.
- Local media (newspapers, cable television and radio) were used to announce community meetings and to inform the public of the MHSA planning activities and contact information.

In addition, the targeted outreach strategy that characterized Phase II ensured that we contacted the following groups via focus groups and/or use of key informant interviews:

County Mental Health Staff
Mental Health Commission Members
MHSA Program members (current consumers)
Center for Violence-Free Relationships
NAMI members
CASA (Court Appointed Special Advocates) volunteers (TAY program)
Shingle Springs Rancheria (Native American services provider, tribe members and elders)
Youth Commission members
MORE (Mother Lode Rehabilitation Enterprises, Inc.) Disabled adults program – staff members
PFLAG (LGBT program) - volunteers
Caregivers Support Groups (various)
United Outreach (homeless services agency) - volunteers
Local Collaboratives
Headstart – Latino parents
Youth Groups (various)
Adult Drug Court Interdisciplinary Team
Teen Drug Court Representative
Juvenile Hall staff member
Alcohol and Drug Program (ADP) providers
School Nurses
School Psychologists
County Office of Education representative
Faith-based community organization members
Foster Parent Association - Representative
First 5 Commission Representative
County Office of Education – staff members
Public Guardian's Office – staff members
Early Childhood Council - Representative
Department of Human Services – staff members
School District Superintendents – staff members
County Public Health staff
Medical Library staff
County Veterans Services Office
Head Start - employees
Family Resource Centers – staff members
City Police
County Sheriff Department
County Superior Court
District Attorney's Office
Public Defender's Office
State Department of Rehabilitation
Medical Centers, Clinics, Hospitals
Council for Disabilities
Holistic Medicine Practitioners

Context:
Ensuring that the staff capacity, knowledge and skills are in place to address the County diversity issues is an ongoing challenge that is being addressed as part of the MHSA program development process. During the MHSA PEI CPP process, two MHSA Project Management Team members received training regarding use of the California Brief Multicultural Competency Scale - a diversity-training tool designed specifically for mental health practitioners with the goal of moving from cultural sensitivity to cultural competence. The goal has been to provide local Division-wide training for staff and community members over time. Implementation of this strategy, along with other strategies to address diversity of culture and language, has been significantly impacted by the Reduction in Force that took place in recent years. We have lost staff capacity related to this training, diversity, and interpretation and translation skills. Yet, the initial stage of this training process is reflected in this year's Quality Improvement Committee plan as part of the Cultural Competency sub-committee plan.

PEI NEW PROGRAM DESCRIPTION

Race/Ethnicity:
The County demographics based on the 2000 Census were used during the MHSA CSS planning phase – a re-assessment pending the Census findings in 2010 will need to be conducted. To date, however, the EDC population profile is, as follows:

Race/Ethnicity:	
African American	0.7%
Asian American	2.7%
Latino	11.0%
Native American	1.4%
Caucasian	82.0%
Other	2.2%

Targeted outreach occurred where there were known groups or places where the Latino and Native American populations could be reached (English as a Second Language/ESL classes, Latino Family Resource Center, and the Rancheria). Together with the Caucasian population, this comprises 94.4% of the County population. The challenge is significant in relationship to outreach to the African American and Asian populations – together they comprise 3.4% of the County population – and we have not yet identified any particular group or setting to target for outreach purposes. It is unclear what comprises the category of "Other" but there is a growing population of Russian immigrants in the western County area closer to Sacramento. We have identified one potential contact person by which to begin to reach this population and a few of these stakeholders were represented in an outreach group.

Youth with disabilities, African American and Asian middle school students were among youth reached in the context of a special all day event which targeted youth who self-identified with a unique group or identity – typically along the lines of race/ethnicity. A MHSA team member participated in this event as a group facilitator. This event solicited their input in relationship to the exploratory question: "What is needed to help students like yourselves successfully move from middle to high school?" Issues of concerns with bullying were predominant, as was the feedback related to a need for the student voice in planning and decision-making.

Efforts to maintain feedback and dialogue with underserved populations have improved to a degree with experience and diversified MHSA service providers (Latino and Native American). The MHD is committed to continuing our efforts to improve further.

Language
Targeted outreach to the Latino population included use of bilingual/bicultural staff, focus groups at churches, ESL classes and a Latino Community Family Resource Center (FRC). In one interesting scenario, an ESL class hosted by the Latino Community FRC included a Vietnamese individual. During Phase I, extensive work was invested in getting materials translated into Spanish – including the Executive Summary of the original CSS plan. Furthermore, we had individuals at many of our key presentations available to provide interpretation for Spanish-speaking individuals. Our findings were that these resources were not utilized and that targeted outreach to small groups was a far more effective technique to engage this population in our community.

Geographic Regions
As indicated earlier, to address the separation of the Western Slope Region from South Lake Tahoe, we used teleconferencing equipment for almost all of the planning meetings. MHSA PEI training took place in person in SLT, as well, on two occasions. The Western Slope Region is expansive and beyond the County seat of Placerville, includes a community in the east (Pollock Pines), a community in the southern region (Somerset), a community to the north (Georgetown Divide), and one to the west (Cameron Park-El Dorado Hills). In addition to what is outlined below, outreach to existing community collaboratives did occur in Georgetown and El Dorado Hills. Greater efforts to identify effective ways to reach Pollock Pines and Somerset need to be made in the future.

Age Groups
Middle school, TAY, and high school students were reached via targeted outreach and/or participation in the planning meetings. There is an active EDC youth voice - they participate on their own commission (for example, giving feedback to the County regarding safety issues related to the Skate Board Park) and as full members on the El Dorado Hills Vision Coalition – and these groups were accessed as part of the MHSA PEI CPP process.

Gender and LGBT
Targeted outreach served to solicit feedback from representatives of PFLAG and other agencies that address domestic violence. The issues of personal safety and outreach to enhance access to services were important themes relevant to PEI planning.

Through this process, the identification of the priority populations specific to the Community Education Project is emerged from the analysis of the combination of high risk factors and limited resources for the TAY and LGBT population, the need for strategies to reach individuals and families for whom transportation served as a barrier, and the recognized value of learned experience in promoting health, supporting recovery, and building capacity.

It is the intention of this program to better reach the un-served and under-served populations in a cost-effective manner. Each of the methods proposed include use of peers or materials that designed to increase access. Each component program will be asked to have a specific plan regarding targeting and access for the underserved populations and to report on their results in the year-end progress report.

3. PEI Program Description (attach additional pages, if necessary).

The Mental Health Promotions or Prevention Goal - Promotion of mental health through knowledge, education and skills training and the building of community capacity to promote mental health through community education. This strategy emphasizes the key role of diversity, consumers, and family in strengthening communities.

Intervention Strategies/Models - The Community Education Project diversity and expand its educational strategies:

Parenting Wisely Program (Selective and Indicated Prevention Approaches)
This parent training program targets parents with children ages 5-18. The Parenting Wisely Program uses a self-administered, interactive and multimedia CD-ROM as the training vehicle and thereby overcomes illiteracy and transportation barriers. This program is based on social learning theory, family systems theory, and cognitive theory and seeks to help families improve relationships and decrease conflict by improving parenting skills and enhancing family communication, mutual support, supervision and discipline. This program is recognized by SAMSHA as a model program. In the initial year, we proposed the purchase of ten (10) CD-ROMs for county-wide use. Much interest has been generated among our partner agencies and staff and we also determined that there is another set of materials targeting adolescents. Therefore, we intend to annualize this plan by purchasing ten (10) additional CD-ROMs in both English and Spanish.

NAMI training capacity building (Selective and Indicated Prevention Approaches)
The National Alliance on Mental Illness (NAMI) serves to provide awareness, education and advocacy as a means to offer hope, reform and health to the community. This group began in 1979 and represents families, friends and individuals affected by mental illness.

The local NAMI chapters have been successfully providing the Family to Family Program (a 12-week course provided to families, friends, and caregivers and community members) by NAMI volunteers free of cost. The family education approach is based on theories of stress, coping, and adaptation. The primary outcome of concern in family education is the well-being of the family and the program is not diagnosis-specific. This family education model provides information, coping skills training, and collaboration skills training. Enhancement of protective factors for family members serves as an early intervention strategy that positively impacts the recovery process of mental health consumers.

This 12-week program is taught by trained family member volunteers with the use of a highly structured, scripted manual. In weekly two- to three-hour sessions, family caregivers receive information about mental illnesses, treatments and medication, and rehabilitation. They learn self-care and communication skills as well as problem-solving and advocacy strategies.

While the research on the Family-to-Family Education Program is limited, a few studies have found that family members who participate in family education programs have greater knowledge and self-efficacy and are more satisfied with the patient's treatment than those who do not. In addition, the participants experienced significantly greater family, community, and service system empowerment and reduced displeasure and worry about the family member who had a mental illness.

This fiscal year, the Western Slope NAMI Chapter has been re-evaluating their needs and is proposing to expand the repertoire of classes available locally by sending three members to get trained as trainers in the following areas:

NAMI Basics Education:
The program is for parents and other caregivers of children and adolescents living with mental illnesses. The course is taught by trained/certified teachers who are the parents/caregivers of individuals who developed the symptoms of mental illness prior to the age of 13 years. The course consists of six classes offered weekly.

Provider Education:
The NAMI Provider Education Program is a 10-week course that presents a penetrating, subjective view of family and

consumer experiences with serious mental illness to line staff at public agencies who work directly with people with severe and persistent mental illnesses. This course helps providers realize the hardships that families and consumers face and appreciate the courage and persistence it takes to live with and recover from mental illness. A training plan and progress report for the fiscal year will be submitted to the MHD. MHSA funds are being request to cover travel costs not funded by NAMI.

PFLAG Community Education (Universal, Selective and Indicated Prevention Approaches)

As an approved PEI program under Community Education, the MHD is partnering with Parents, Families, Friends of Lesbians and Gays (PFLAG) to provide outreach, education and training to mental health providers and interested community members. PFLAG provides an opportunity for dialogue about sexual orientation and gender identity and acts to create a society that is healthy and respectful of human diversity. Their mission is to support diversity, community involvement to build understanding, education to reduce stigma, and advocacy to end discrimination.

To support this plan, funding will continue to be made available for informational packets and educational materials that PFLAG volunteers present to participants of their program. Volunteers will present the information kits together with a short training session to the target audience in partnership. Outreach costs such as mileage reimbursement, postage, packet materials and other multimedia information, and food costs may be paid for as well. An outreach plan and year-end progress report will be submitted to the MHD.

Community Information Access

Under this program, a Community Access Site (CAS) or web-based community education and information resource center for consumers of mental health services, family members and community stakeholders will be initiated, as well. This community referral site provides free access to a comprehensive library of interactive online courses targeting the general public.

Topics include:

- General mental health
- Addiction, treatment and recovery
- Issues facing families
- Needs of children and adolescents
- Living with mental illness and working toward recovery
- Workforce skills – including basic computer training
- Issues related to older adults
- Needs of returning veterans
- WRAP information Center.

In addition, areas for community news, a resource finder, and a newsfeed and research center are included in the design. Native Language Translation is provided via Google Translate which is embedded in CAS and allows visitors to convert web text to their native language.

Resources will be leveraged as the MHSA WET Action #2: Workforce Development. WET funds were previously approved to support the establishment of web-based professional education for the staff. This CAS site serves as an extremely cost-effective expansion component targeting community education.

Consumer Leadership Academy

This program will include a Leadership Academy providing educational opportunities designed to inform and empower consumers in relationship to meaningful participation in the broader community. This program has begun locally as a grassroots effort with very favorable response on both slopes. Consumers have identified a need for support related to transportation assistance, funding for food during activities, and training resources and fees. In addition, funding and the establishment of a stipend program to address costs incurred for participants will be pursued. One desired outcome is increased participation on the Mental Health Commission. Training will also be pursued through the California Institute on Mental Health (CIMH) for Mental Health Board Trainings and through the MHSA WET Regional Collaborative for the Recovery-Oriented Leadership series. Peer counselor training may also be included in future Leadership Academy training events.

For the Consumer Leadership Academy activities, transportation assistance for county-wide events will be made available on a quarterly basis. Healthy snacks will be funded for locally held monthly consumer meetings at both SLT and WS. Staff support for a range of these events will be provided, as well. The WET Coordinator, Patients Rights Advocate, and

Volunteer Coordinators, and Mental Health Aides on both slopes will collaborate with consumers on this project. A meaningful role in the community may serve to be one of the most effective preventive measures to relapse to illness.

Mental Health First Aid

The MHD proposes to engage the local community and participate in a training program sponsored by the Central Region Collaborative to establish community Mental Health First Aid Trainers. These individuals will attend a weeklong training fully funded by the Central Region MHSA WET funds and return to the County to provide the training described below.

The Mental Health First Aid program is an interactive session which runs 12 hours and provides certification which must be renewed every three years. This training introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and provides an overview of common treatment modalities. Mental Health First Aid is designed to give members of the public key skills to help someone who is developing a mental health problem or experiencing a mental health crisis. The evidence behind the program demonstrates that it does build mental health literacy and helps the public to identify, understand and respond to signs of mental illness.

Just as CPR training helps a layperson with no clinical training assist an individual following a heart attack, Mental Health First Aid training helps a layperson assist someone experiencing a mental health crisis, such as contemplating suicide. In both situations, the goal is to help support an individual **until appropriate professional** help arrives. Mental Health First Aiders learn a single 5-step strategy that includes assessing risk, respectfully listening to and supporting the individual in crisis, and identifying appropriate professional help and other supports. Participants are also introduced to risk factors and warning signs for mental health or substance use problems, engage in experiential activities that build understanding of the impact of illness on individuals and families; and learn about evidence-supported treatment and self-help strategies.

Specifically, participants learn:

- The potential risk factors and warning signs for a range of mental health problems, including: depression, anxiety/trauma, psychosis, eating disorders, substance use disorders, and self-injury
- An understanding of the prevalence of various mental health disorders in the U.S. and the need for reduced stigma in their communities
- A 5-step action plan encompassing the skills, resources and knowledge to assess the situation, to select and implement appropriate interventions, and to help the individual in crisis connect with appropriate professional care
- The evidence-based professional, peer, social, and self-help resources available to help someone with a mental health problem.

Audiences can include key professions, such as law enforcement and other first responders, nursing home staff, and school administration. Other participating entities include faith communities, employers and chambers of commerce, state policymakers, mental health advocacy organizations, families and the general public.

Mental Health First Aid has a strong evidence base. Four detailed studies have been completed - one trial found that those who trained in Mental Health First Aid have greater confidence in providing help to others, greater likelihood of advising people to seek professional help, improved concordance with health professionals about treatments, and decreased stigmatizing attitudes. The study also found that Mental Health First Aid improved the mental health of the participants.

Mental Health First Aid in the US can become as common as CPR and First Aid. It has the potential to reduce stigma, improve mental health literacy, and empower individuals. As such, it has great potential as a community capacity building educational strategy. Staff and community members will be invited to become trainers and develop a county training plan.

PEI NEW PROGRAM DESCRIPTION

4. Activities

Activity Title	Proposed number of individuals or families through PEI expansion to be served through June 2011 by type of prevention:			Number of months in operation through June 2011
		Prevention	Early Intervention	
Parenting Wisely	Individuals: Families:	 100		12
NAMI train the trainer	Individuals: Families:	 5		12
PFLAG	Individuals: Families:	100		12
Community Access Center	Individuals: Families:	100		6
Leadership Academy	Individuals: Families:	30		6
Mental Health First Aid	Individuals: Families:	60		6
Total PEI Program Estimated Unduplicated Count of Individuals to be Served	Individuals: Families:	290 105		

5. Describe how the program links PEI participants to County Mental Health and providers of other needed services

Community education, capacity and asset-building is the theme of this Community Education Program. Each of these programs will serve to decrease stigma, remove barriers, and to provide information regarding access to the MHD and other services in an extremely cost-effective manner. Training regarding the available mental health and MHSA services will be provided as well as a designated contact person for inquiries. The Community Navigator proposed under the Health Disparities Program #7 will be responsible for conducting an updated community assessment, asset mapping, and subsequent community training related to the local services available to the community.

6. Describe collaboration with and system enhancements of other partners such as community based organizations, schools, and primary care.

This strategy represents a commitment to collaboration with parents and advocacy groups, as well as an effort to support independent learning. Capacity building among families and advocacy groups serves to enhance the community safety net system.

7. Describe intended outcomes.

Overall – Increased knowledge, skills, and decreased stigma by use of cost-effective strategies that address barriers and under-served populations.

Parenting Wisely:

- Improvements in behaviors related to protective factors – general family functioning, family cohesion and parent-child bonding, family organization and unity, effectiveness of discipline, parental involvement with children and their schoolwork, supervision of school and peer activities, school grades, knowledge and use of good parenting skills, problem solving, and clear expectations.
- Reductions in behaviors related to risk factors - child problem/conduct behavior, maternal depression, parental use of physical punishment and yelling, spousal violence and violence toward children.
- Other outcomes include high parental ratings of interest, relevance, ease of use, and confidence in using parenting skills taught; increased participation in further parent education classes, teaches parents effective child supervision and disciplinary skills, resulting in increased bonding; improves family problem solving, which decreases conflict and improves family cohesion; increases parents' self-efficacy and validates their strengths; decreases coercive and authoritarian parenting practices, thereby reducing conflict; reduces blaming attributions, thereby increasing cooperative interactions; teaches a family systems perspective to reduce scapegoating.
- For children, clinically significant behavior improvement occurred during the time that their parents used the program.
- **Program completion rates for parents ranged from 83-91%.**

NAMI's Family to Family:

- Increased knowledge and coping skills thereby enhancing family resilience to deal with serious mental illness.

PFLAG's Community Education Program:

- Increased knowledge, sensitivity and awareness designed to decrease stigma and increase tolerance and acceptance, and ultimately access to services for the LGBT population.
- Reduction of risk factors for depression and suicide and improved mental and emotional health of an extremely high-risk population.
- Fewer incidents of harassment

8. Describe coordination with Other MHSA Components.

MHSA CSS and WET program staff will be provided with information regarding these programs and how to educate clients and families regarding access to these resources. These programs serve to enhance the work done in the Wellness Centers and leverage efforts outlined in the WET plan.

The WET Coordinator will be looking for opportunities to merge workforce development and the need for capacity building in the arena of prevention and health promotions in collaboration with the MHSA Program Manager.

The other MHSA components are still under development.

9. Provide a budget narrative for costs identified for this Program, as outlined in Exhibit F. Please include the number of FTE personnel positions/classifications and a brief description of each FTE's functions. Please include a brief description of operating costs, subcontracts/professional services, and non-recurring expenditures associated with this PEI Program.

Budgeting for this program consists of $11,707 in personnel costs (salaries, benefits and taxes) for staff:

- 0.04 FTE (82 hours) each for a Mental Health Clinician and a Mental Health Aide and 0.01 FTE (20 hours) Mental Health Program Coordinator to conduct and/or facilitate consumer and volunteer training activities;
- 0.02 FTE (40 hours) for a driver to provide transportation in order to bring participants from the West Slope and South Lake Tahoe together for collaborative events.
- 0.05 FTE (112 hours) total of Mental Health Clinician time to serve as Mental Health Aid Trainers for the community.

We have also budgeted one non-recurring purchase:

- $10,000 to purchase Parenting Wisely materials targeting adolescents: ten (10) CD-ROMs in both English and Spanish ($1,000 each)

And we have budgeted for additional training and professional services that we expect to be a one-time expense:

- $10,000 in consultant fees for the Consumer and Family Leadership Academy
- $1,200 to host professional training provided by staff from CiMH

Additional operating expenditures consist of:

- $2,000 to support NAMI training
- $2,000 to purchase materials and support PFLAG outreach, education and training activities
- $2,251 in facility, indirect and overhead costs required to support the program. Operating expenditures include costs allocated based on the former OMB A-87 Federal Register (now Title 2, Federal Regulations (CFR), Subtitle A, Chapter ii, Part 225), including facility expenses such as rent, utilities, and janitorial services, as well as other operating expenditures such as clinical management, computing equipment and software licensing.
- $2000 for travel, training, food and materials to introduce and recruit participants for the educational programs
- $5000 to establish a stipend program

In addition, we plan to purchase and incorporate various professional services:

- $12,400 to initiate, develop and host a Community Access Site (CAS) for web-based community education and information for consumers of mental health services, family members and community stakeholders

In sum, the program budget totals $69,109**.**

10. Additional Comments (Optional)

None.

County: El Dorado Date: 28-Sep-10

Program/Project Name and #: PEI #4 Community Education Project

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. EXPENDITURES				
Community Services and Supports				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Expenditures when service provider is not known				$0
6. Non-recurring expenditures				$0
7. Other Expenditures*				$0
8. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Workforce Education and Training				
1. Personnel Expenditures				$0
2. Operating Expenditures				$0
3. Training Expenditures				$0
4. Training Consultant Contracts				$0
5. Residency Expenditures				$0
6. Internship Expenditures				$0
7. Mental Health Career Pathway Expenditures				$0
8. Stipend Funds				$0
9. Scholarship Funds				$0
10. Loan Repayment Funds				$0
11. Non-recurring Expenditures				$0
12. Other Expenditures*				$0
13. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Capital Facilities				
1. Pre-Development Costs				$0
2. Building/Land Acquisition				$0
3. Renovation				$0
4. Construction				$0
5. Repair/Replacement Reserve				$0
6. Other Expenditures*				$0
7. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Technological Needs				
1. Personnel				$0
2. Hardware				$0
3. Software				$0
4. Contract Services				$0
5. Other Expenditures*				$0
6. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Prevention and Early Intervention (PEI)				
1. Personnel	$11,707			$11,707
2. Operating Expenditures	$18,802		$5,000	$23,802
3. Non-recurring Expenditures	$10,000		$11,200	$21,200
4. Subcontracts/Professional Services			$12,400	$12,400
5. Other				$0
6. Total Proposed Expenditures	**$40,509**	**$0**	**$28,600**	**$69,109**

Innovation (INN)						
	1. Personnel					$0
	2. Operating Expenditures					$0
	3. Non-recurring Expenditures					$0
	4. Training Consultant Contracts					$0
	5. Work Plan Management					$0
	6. Other					$0
	7. Total Proposed Expenditures		**$0**	**$0**	**$0**	**$0**
B. REVENUES						
	1. New Revenues					
	a. Medi-Cal (FFP only)					$0
	b. State General Funds					$0
	c. Other Revenue					$0
	2. Total Revenues		**$0**	**$0**	**$0**	**$0**
C. TOTAL FUNDING REQUESTED			**$40,509**	**$0**	**$28,600**	**$69,109**

***Enter the justification for items that are requested under the "Other Expenditures" category.**

Justification:

Please include your budget narrative on a separate page.

Prepared by: Janet Stevens

Telephone Number: (530) 621-6226

PEI NEW PROGRAM DESCRIPTION EXHIBIT F cont.
BUDGET NARRATIVE

Action #4 – Community Education

Budgeting for this program consists of $11,707 in personnel costs (salaries, benefits and taxes) for staff:

- 0.04 FTE (82 hours) for a Mental Health Clinician and 0.01 FTE (20 hours) Mental Health Program Coordinator to conduct and/or facilitate consumer and volunteer training activities.
- 0.04 FTE (82 hours) for a Mental Health Aide to support the Consumer Leadership Academy.
- 0.02 FTE (40 hours) for a driver to provide transportation in order to bring participants from the West Slope and South Lake Tahoe together for Consumer Leadership Academy collaborative events.
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- $2000 for travel, training, food and materials to introduce and recruit participants for the educational programs
- $5000 to establish a consumer Leadership Academy stipend program

In addition, we plan to purchase and incorporate various professional services:

- $12,400 to initiate, develop and host a Community Access Site (CAS) for web-based community education and information for consumers of mental health services, family members and community stakeholders

In sum, the program budget totals $69,109

2010/11 ANNUAL UPDATE **EXHIBIT D**

PREVIOUSLY APPROVED PROGRAM

County: El Dorado

Program Number/Name: Program #5 - Wennem Wadati

Date: ~~September 28, 2010~~

Select one:

☐ **CSS**
☐ **WET**
☒ **PEI**
☐ **INN**

Prevention and Early Intervention				
No.	**Question**	**Yes**	**No**	
1.	Is this an existing program with no changes?	☐	☒	If yes, complete Exh. E4; If no, answer question #2
2.	Is there a change in the Priority Population or the Community Mental Health Needs?	☐	☒	If yes, completed Exh. F4; If no, answer question #3
3.	Is the current funding requested greater than15% of the previously approved amount?	☐	☒	If yes, complete Exh. F4; If no, answer question #4
4.	Is the current funding requested greater than 35% less of the previously approved amount?	☐	☒	If yes, complete Exh. F4; If no, answer questions 5, 5a, and 5b
5.	Describe the proposed changes to the Previously Approved Program and the rationale for those changes.			
This program will be implemented for the first time in FY 10-11. The budget therefore has been adjusted to reflect the period of operation that is expected within this fiscal year.				
5a.	If the total number of Individuals to be served annually is different than previously reported please provide revised estimates Total Individuals: __330_____ Total Families: ___60___			
5b.	If the total number of clients by type of prevention annually is different than previously reported please provide revised estimates:	**Prevention**		**Early Intervention**
	Total Individuals:	280		50
	Total Families:	60		

Existing Programs to be Consolidated				
No.	**Question**	**Yes**	**No**	
1.	Is this a consolidation of two or more existing programs?	☐	☒	If yes, answer question #2; If no, answer questions for existing program above
2.	Is there a change in the Priority Population or the Community Mental Health Needs?	☐	☐	If no, answer question #3; If yes, complete Exh. F4
3.	Will the consolidated programs continue to serve the same estimated number of individuals?	☐	☐	If yes, answer question #4; If no, complete Exh. F4
4.	Description of Previously Approved Programs to be consolidated. Include in your description: a) The names of Previously Approved programs to be consolidated, b) How the Previously approved programs will be consolidated; and c) Provide the rationale for consolidation			

*PEI Projects previously approved are now called Previously Approved Programs

2010/11 ANNUAL UPDATE **EXHIBIT D**

PREVIOUSLY APPROVED PROGRAM

County: El Dorado

Program Number/Name: Program #6 - Home-delivered Meals Wellness Outreach Program for Older Adults

Date: September 28, 2010

Select one:
- ☐ **CSS**
- ☐ **WET**
- ☒ **PEI**
- ☐ **INN**

Prevention and Early Intervention				
No.	**Question**	**Yes**	**No**	
1.	Is this an existing program with no changes?	☐	☒	If yes, complete Exh. E4; If no, answer question #2
2.	Is there a change in the Priority Population or the Community Mental Health Needs?	☒	☐	If yes, completed Exh. F4; If no, answer question #3
3.	Is the current funding requested greater than15% of the previously approved amount?	☒	☐	If yes, complete Exh. F4; If no, answer question #4
4.	Is the current funding requested greater than 35% less of the previously approved amount?	☐	☒	If yes, complete Exh. F4; If no, answer questions 5, 5a, and 5b
5.	Describe the proposed changes to the Previously Approved Program and the rationale for those changes.			
The proposed name change is Wellness Outreach Program (WOP). The proposed change to the priority population is an expansion to the adult population. The Meals on Wheels Wellness and Outreach Program for Older Adults will remain intact and serve as the evaluation component program for PEI. The Mental Health Prevention Goal is proposed to be expanded to include early identification and intervention to mitigate the impact of mental distress and isolation within the adult population. The rationale for this proposed program expansion is based on community feedback regarding vulnerable adults who may not qualify for specialty mental health services and/or who may not be accessing mental health services but who are experiencing the risk factors associated with suicide, depression and isolation, limited social supports, and exposure to trauma – as addressed by this program. The intention is to expand the mechanisms for identification of vulnerable adults and referrals for screening and service linkage beyond the home-delivered meals program that exclusively targets older adults.				
5a.	If the total number of Individuals to be served annually is different than previously reported please provide revised estimates Total Individuals: __466__ Total Families: _110__			
5b.	If the total number of clients by type of prevention annually is different than previously reported please provide revised estimates:	**Prevention**	**Early Intervention**	
	Total Individuals:	370	96	
	Total Families:	88	22	

Existing Programs to be Consolidated				
No.	**Question**	**Yes**	**No**	
1.	Is this a consolidation of two or more existing programs?	☐	☒	If yes, answer question #2; If no, answer questions for existing program above
2.	Is there a change in the Priority Population or the Community Mental Health Needs?	☐	☐	If no, answer question #3; If yes, complete Exh. F4
3.	Will the consolidated programs continue to serve the same estimated number of individuals?	☐	☐	If yes, answer question #4; If no, complete Exh. F4
4.	Description of Previously Approved Programs to be consolidated. Include in your description: a) The names of Previously Approved programs to be consolidated, b) How the Previously approved programs will be consolidated; and c) Provide the rationale for consolidation			

*PEI Projects previously approved are now called Previously Approved Programs

2010/11 ANNUAL UPDATE **EXHIBIT F4**

PEI NEW PROGRAM DESCRIPTION

County: El Dorado

Program Number/Name: Program #6 – Wellness Outreach Program for Vulnerable Adults

Date: September 28, 2010

Instructions: Utilizing the following format please provide responses and refer to the instructions provided in the original PEI Guidelines, as noted in DMH Information Notices No.: 07-19 and 08-23. Complete this form for each new PEI Program and existing PEI Programs that made changes to Key Community Mental Health Needs, Priority Population, and/or funding as described in the Information Notice.

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
1. Disparities in Access to Mental Health Services	☐	☒	☒	☒
2. Psycho-Social Impact of Trauma	☐	☒	☒	☒
3. At-Risk Children, Youth and Young Adult Populations	☐	☒		
4. Stigma and Discrimination	☐	☒	☒	☒
5. Suicide Risk	☐	☒	☒	☒

2. PEI Priority Population(s) **Note: All PEI programs must address underserved racial/ethnic and cultural populations.**	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
1. Trauma Exposed Individuals	☐	☒	☒	☒
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☒	☒	☒
3. Children and Youth in Stressed Families	☐	☒		
4. Children and Youth at Risk for School Failure	☐	☒		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☐	☒		
6. Underserved Cultural Populations	☐	☒	☒	☒

a. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s) and describe how the PEI program will reach/engage unserved and underserved multicultural communities.

A key feature of ensuring comprehensive and representative participation was providing a range of avenues for input and decision-making. Opportunities to participate in the Community Program Planning (CPP) process were ensured by mechanisms for information dissemination (announcements in meetings and groups attended by stakeholders, posted fliers, mass mailings, and the MHSA website providing meeting announcements, updates, and meeting minutes), education and training, outreach (comprehensive and targeted), open planning meetings, and a representative MHSA Advisory Committee. Options for anonymous input included a local phone line with a voice mailbox, an e-mail address, and use of written and online surveys. Outreach efforts included community meetings, readiness trainings, focus groups and key informant interviews which were intended to offer convenient one-time opportunities to gain information about the MHSA and to offer feedback. The detailed planning occurred in the planning and advisory committee meetings which were arenas for ongoing involvement. During Phase I, a mailing list of 390 individuals was created and over 500 survey questionnaires were completed. During Phase II, the mailing list expanded to 450 and over 185 survey questionnaires were completed.

El Dorado County's efforts to ensure a comprehensive and representative MHSA planning process included the following accomplishments during Phase I:

- 82 focus groups and readiness trainings reaching 925 respondents
- 23 key informant interviews
- 5 written surveys with a total of 545 responses
- An MHSA mailing list of 390 individuals used to send out announcements, surveys, meeting notifications, and updates.
- Local media (newspapers, cable television and radio) were used to announce community meetings and to inform the public of the MHSA planning activities and contact information.

In addition, the targeted outreach strategy that characterized Phase II ensured that we contacted the following groups via focus groups and/or use of key informant interviews:

County Mental Health Staff
Mental Health Commission Members
MHSA Program members (current consumers)
Center for Violence-Free Relationships
NAMI members
CASA (Court Appointed Special Advocates) volunteers (TAY program)
Shingle Springs Rancheria (Native American services provider, tribe members and elders)
Youth Commission members
MORE (Mother Lode Rehabilitation Enterprises, Inc.) Disabled adults program – staff members
PFLAG (LGBT program) - volunteers
Caregivers Support Groups (various)
United Outreach (homeless services agency) - volunteers
Local Collaboratives
Headstart – Latino parents
Youth Groups (various)
Adult Drug Court Interdisciplinary Team
Teen Drug Court Representative
Juvenile Hall staff member
Alcohol and Drug Program (ADP) providers
School Nurses
School Psychologists
County Office of Education representative
Faith-based community organization members
Foster Parent Association - Representative
First 5 Commission Representative
County Office of Education – staff members
Public Guardian's Office – staff members
Early Childhood Council - Representative
Department of Human Services – staff members
School District Superintendents – staff members
County Public Health staff
Medical Library staff
County Veterans Services Office
Head Start - employees
Family Resource Centers – staff members
City Police
County Sheriff Department
County Superior Court
District Attorney's Office
Public Defender's Office
State Department of Rehabilitation
Medical Centers, Clinics, Hospitals
Council for Disabilities
Holistic Medicine Practitioners

Context:
Ensuring that the staff capacity, knowledge and skills are in place to address the County diversity issues is an ongoing challenge that is being addressed as part of the MHSA program development process. During the MHSA PEI CPP process, two MHSA Project Management Team members received training regarding use of the California Brief Multicultural Competency Scale - a diversity-training tool designed specifically for mental health practitioners with the goal of moving from cultural sensitivity to cultural competence. The goal has been to provide local Division-wide training for staff and community members over time. Implementation of this strategy, along with other strategies to address diversity of culture and language, have been significantly impacted by the Reduction in Force that took place in recent years. We have lost staff capacity related to this training, diversity, and interpretation and translation skills. Yet, the initial stage of this training process is reflected in this year's Quality Improvement Committee plan as part of the Cultural Competency sub-committee plan.

PEI NEW PROGRAM DESCRIPTION

Race/Ethnicity:
The County demographics based on the 2000 Census were used during the MHSA CSS planning phase – a re-assessment pending the Census findings in 2010 will need to be conducted. To date, however, the EDC population profile is, as follows:

Race/Ethnicity:	
African American	0.7%
Asian American	2.7%
Latino	11.0%
Native American	1.4%
Caucasian	82.0%
Other	2.2%

Targeted outreach occurred where there were known groups or places where the Latino and Native American populations could be reached (English as a Second Language/ESL classes, Latino Family Resource Center, and the Rancheria). Together with the Caucasian population, this comprises 94.4% of the County population. The challenge is significant in relationship to outreach to the African American and Asian populations – together they comprise 3.4% of the County population – and we have not yet identified any particular group or setting to target for outreach purposes. It is unclear what comprises the category of "Other" but there is a growing population of Russian immigrants in the western County area closer to Sacramento. We have identified one potential contact person by which to begin to reach this population and a few of these stakeholders were represented in an outreach group.

Youth with disabilities, African American and Asian middle school students were among youth reached in the context of a special all day event which targeted youth who self-identified with a unique group or identity – typically along the lines of race/ethnicity. A MHSA team member participated in this event as a group facilitator. This event solicited their input in relationship to the exploratory question: "What is needed to help students like yourselves successfully move from middle to high school?" Issues of concerns with bullying were predominant, as was the feedback related to a need for the student voice in planning and decision-making.

Efforts to maintain feedback and dialogue with underserved populations have improved to a degree with experience and diversified MHSA service providers (Latino and Native American). The MHD is committed to continuing our efforts to improve further.

Language
Targeted outreach to the Latino population included use of bilingual/bicultural staff, focus groups at churches, ESL classes and a Latino Community Family Resource Center (FRC). In one interesting scenario, an ESL class hosted by the Latino Community FRC included a Vietnamese individual. During Phase I, extensive work was invested in getting materials translated into Spanish – including the Executive Summary of the original CSS plan. Furthermore, we had individuals at many of our key presentations available to provide interpretation for Spanish-speaking individuals. Our findings were that these resources were not utilized and that targeted outreach to small groups was a far more effective technique to engage this population in our community.

Geographic Regions
As indicated earlier, to address the separation of the Western Slope Region from South Lake Tahoe, we used teleconferencing equipment for almost all of the planning meetings. MHSA PEI training took place in person in SLT, as well, on two occasions. The Western Slope Region is expansive and beyond the County seat of Placerville, includes a community in the east (Pollock Pines), a community in the southern region (Somerset), a community to the north (Georgetown Divide), and one to the west (Cameron Park-El Dorado Hills). In addition to what is outlined below, outreach to existing community collaboratives did occur in Georgetown and El Dorado Hills. Greater efforts to identify effective ways to reach Pollock Pines and Somerset need to be made in the future.

Age Groups
Middle school, TAY, and high school students were reached via targeted outreach and/or participation in the planning meetings. There is an active EDC youth voice - they participate on their own commission (for example, giving feedback to the County regarding safety issues related to the Skate Board Park) and as full members on the El Dorado Hills Vision Coalition – and these groups were accessed as part of the MHSA PEI CPP process.

Gender and LGBT
Targeted outreach served to solicit feedback from representatives of PFLAG and other agencies that address domestic violence. The issues of personal safety and outreach to enhance access to services were important themes relevant to PEI planning.

The identification of the priority populations then resulted from community concerns related to clients who were no longer engaged in treatment and concerns about limited access to services. Vulnerability of adults who are isolated and/or who were not eligible for various social service systems were identified as a priority issue and the need to outreach to these individuals and ensure a safety net was proposed as an approach to pilot given the limited capacity of the MHD at this time.

This expansion proposal specifies that the un-served and under-served populations will be reached via partnership with volunteer programs that have "eyes on" in the community, utilization of outreach workers, and the availability to provide some early screening, service linkage and drop in group services for vulnerable adults.

3. PEI Program Description (attach additional pages, if necessary).

Mental Health Prevention Goal – Collaboration with community partners, outreach, community education, early identification and intervention to mitigate the impact of mental distress.

Approach – Selected and Indicated Prevention.

Age group – Adults (18+)

Determinants to be addressed: Risk factors associated with suicide – depression and isolation, limited social supports, and exposure to trauma.

Intervention Strategy/Model:
The Outreach Program for Vulnerable Adults will address vulnerability due to mental distress and isolation. Various strategies will be employed including outreach and engagement services, early identification, screening, service linkage, and safety net brief mental health services.

A. Partnership with the existing Home-Delivered Meals program provided by the County Human Services Department – which currently serves approximately 800 seniors - by funding Health Services services to 1) provide education and training related to mental health issues to staff, volunteers, clients and community members, 2) screen for older adults and caregivers for depression, and 3) provide brief treatment and/or referral, as appropriate. This model serves to decrease risk factors, increase protective factors, and provides community-based support. Programs and tools with demonstrated success (i.e., Gatekeepers model, use of the PHQ-9) will be applied in this program. The required PEI program evaluation project will continue to focus on this component program.

B. Partnership with NAMI and the STARs program - Sheriff's Team of Active Retirees – which utilizes senior volunteers who complete a three-week course in law enforcement, communications, and first aid to be the "eyes and ears" of the Sheriff's Department. This program expansion proposes to provide additional training for interested volunteers regarding the signs of mental distress. These individuals can then do welfare checks on adults who have been identified by NAMI and the MHD as vulnerable and isolated individuals. Mechanisms for early intervention services will be provided, as well. As such, incorporation of the MHD's partnership with NAMI and the STARs program serves to build the capacity to serve the community in a pro-active manner.

C. Partnership with the MHD's Wellness Center by establishing extensions of this program in two ways. 1) Wellness Outreach Ambassadors will serve as another layer of early intervention by applying use of outreach and early identification of vulnerable adults, screening and service linkage for mental health services, substance abuse screening, and primary healthcare services; and 2) the Clubhouse Membership Program will allow some program capacity to provide screening, service linkage and time-limited rehabilitative services to adults who may not require specialty mental health services but who are deemed "at-risk" of needing such services and who can potentially benefit from services offered in the Wellness Center.

PEI NEW PROGRAM DESCRIPTION

4. Activities

Activity Title	Proposed number of individuals or families through PEI expansion to be served through June 2011 by type of prevention:			Number of months in operation through June 2011
		Prevention	Early Intervention	
Home-delivered Meals Wellness Outreach Component	Individuals: Families:	350 88	76 22	
STARs	Individuals: Families:	20	20	
Wellness Outreach Ambassadors and linkage to Clubhouse Memberships	Individuals: Families:	10	10	
Total PEI Program Estimated Unduplicated Count of Individuals to be Served	Individuals: Families:	458	118	

5. Describe how the program links PEI participants to County Mental Health and providers of other needed services

Many resources will be leveraged to provide services to address identified mental health needs:

- The MHSA WET-funded Friendly Visitor Program will continue to recruit and train volunteers to provide in-home support for interested and appropriate candidates.
- The MHSA CSS-funded Wellness and Recovery Services Program will provide assessment, brief treatment, and case management, as appropriate.
- The County Mental Health Division will be accessed for specialty mental health services.
- The Area Agency for Aging (AAA) service delivery system will be accessed for health and social services.
- The existing Senior Peer Counselor Program will be accessed to provide peer support, as appropriate.

Furthermore, linkages to resources in support of sustaining healthy community-based living will be accessed, as well, through the Health Services staff and Wellness Outreach Ambassadors. This may include linkage to supports for physical health, financial, transportation, and social and culturally-specific needs.

6. Describe collaboration with and system enhancements of other partners such as community based organizations, schools, and primary care.

This strengths-based strategy represents an enhancement to existing assets within our community – the Home-Delivered Meals Program and the MHSA CSS Wellness and Recovery Services Program. The existing adult and older adult systems of care will be utilized for referrals and service delivery collaboration through referral and attendance at regular collaborative meetings. Participants include the Human Services, Health Services (including both the Public Health and Mental Health Divisions), Sheriff, and Probation Departments.

7. Describe intended outcomes.

The fundamental goals are:

- To provide early detection and increased access to screening, assessment, and early intervention for depression and suicide.
- To prevent the onset of major depression, to reduce the negative outcomes of untreated depression, and to prevent the tragic consequences of suicide.
- To reduce the risk of institutionalization and homelessness among adults.
- To provide linkage to the appropriate level (least restrictive) of mental health and other needed services.
- To provide training, knowledge and skills related to mental health for clients, family members, and the broader community, thereby promoting mental health and independent living.
- To provide these services in a proactive (outreach) and community (home-based) model thereby reducing disparities in service access for older, vulnerable, and isolated adults.

8. Describe coordination with Other MHSA Components.

Integration with the MHSA CSS programs will occur as a function of incorporating the Older Adult Community Education and Training Program under the PEI component. In addition, referrals to the MHSA CSS-funded Wellness and Recovery Services Program will offer opportunities for further assessment, specialty mental health treatment, and case management for appropriate individuals. Finally, under MHSA Workforce Education and Training, the Friendly Visitor Program will offer options for volunteer and peer support for appropriate older adults. The other MHSA components are still under development.

9. Provide a budget narrative for costs identified for this Program, as outlined in Exhibit F. Please include the number of FTE personnel positions/classifications and a brief description of each FTE's functions. Please include a brief description of operating costs, subcontracts/professional services, and non-recurring

expenditures associated with this PEI Program.

Budgeting for this program consists of the following personnel costs, estimated to total $91,301 for salaries, benefits and taxes:

- 2.0 FTE Mental Health Aides to function as Wellness Outreach Ambassadors. These staff members will provide direct, early outreach services in partnership with existing community support programs (e.g., primary health care providers, NAMI) and within the MHD Wellness Center to provide screening, service linkage and time-limited rehabilitative services to adults who do not require specialty mental health services but are deemed "at-risk". These positions will be staffed both on the West Slope of the County and in South Lake Tahoe.
- 0.2 FTE supervisor positions will provide program oversight in both locations and will provide additional mental health training to interested community partners from the Home-Delivered Meals program, NAMI, STARS, etc.

In addition, we estimate a total of $108,858 in operating expenditures, to include:

- $10,000 in support of outreach activities for both clients and volunteers, to include food, training, travel (mileage), and materials.
- Additional operating expenditures of $98,858 include facility costs such as rent, utilities, and janitorial services on the West Slope and in South Lake Tahoe, as well as indirect and overhead expenses, including clinical management, computing equipment and software licensing required to support the program.

Total program budget: 200,159

10. Additional Comments (Optional)

None.

County: El Dorado Date: 28-Sep-10

Program/Project Name and #: PEI #6 Wellness Outreach Program (WOP)

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. EXPENDITURES				
Community Services and Supports				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Expenditures when service provider is not known				$0
6. Non-recurring expenditures				$0
7. Other Expenditures*				$0
8. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Workforce Education and Training				
1. Personnel Expenditures				$0
2. Operating Expenditures				$0
3. Training Expenditures				$0
4. Training Consultant Contracts				$0
5. Residency Expenditures				$0
6. Internship Expenditures				$0
7. Mental Health Career Pathway Expenditures				$0
8. Stipend Funds				$0
9. Scholarship Funds				$0
10. Loan Repayment Funds				$0
11. Non-recurring Expenditures				$0
12. Other Expenditures*				$0
13. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Capital Facilities				
1. Pre-Development Costs				$0
2. Building/Land Acquisition				$0
3. Renovation				$0
4. Construction				$0
5. Repair/Replacement Reserve				$0
6. Other Expenditures*				$0
7. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Technological Needs				
1. Personnel				$0
2. Hardware				$0
3. Software				$0
4. Contract Services				$0
5. Other Expenditures*				$0
6. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Prevention and Early Intervention (PEI)				
1. Personnel	$91,301			$91,301
2. Operating Expenditures	$108,858			$108,858
3. Non-recurring Expenditures				$0
4. Subcontracts/Professional Services				$0
5. Other				$0
6. Total Proposed Expenditures	**$200,159**	**$0**	**$0**	**$200,159**

Innovation (INN)						
	1. Personnel					$0
	2. Operating Expenditures					$0
	3. Non-recurring Expenditures					$0
	4. Training Consultant Contracts					$0
	5. Work Plan Management					$0
	6. Other					$0
	7. Total Proposed Expenditures		**$0**	**$0**	**$0**	**$0**
B. REVENUES						
	1. New Revenues					
	a. Medi-Cal (FFP only)					$0
	b. State General Funds					$0
	c. Other Revenue					$0
	2. Total Revenues		**$0**	**$0**	**$0**	**$0**
C. TOTAL FUNDING REQUESTED			**$200,159**	**$0**	**$0**	**$200,159**

***Enter the justification for items that are requested under the "Other Expenditures" category.**

Justification:

Please include your budget narrative on a separate page.

Prepared by: Janet Stevens

Telephone Number: (530) 621-6226

PEI NEW PROGRAM DESCRIPTION EXHIBIT F cont.
BUDGET NARRATIVE

Action #6 – Wellness and Outreach Program for Vulnerable Adults

Budgeting for this program consists of the following personnel costs, estimated to total $91,301 for salaries, benefits and taxes:

- 2.0 FTE Mental Health Aides to function as Wellness Outreach Ambassadors. These staff members will provide direct, early outreach services in partnership with existing community support programs (e.g., primary health care providers, NAMI) and within the MHD Wellness Center to provide screening, service linkage and time-limited rehabilitative services to adults who do not require specialty mental health services but are deemed “at-risk”. These positions will be staffed both on the West Slope of the County and in South Lake Tahoe.
- 0.2 FTE supervisor positions will provide program oversight in both locations and will provide additional mental health training to interested community partners from the Home-Delivered Meals program, NAMI, STARS, etc.

In addition, we estimate a total of $108,858 in operating expenditures, to include:

- $10,000 in support of outreach activities for both clients and volunteers, to include food, training, travel (mileage), and materials.
- Additional operating expenditures of $98,858 include facility costs such as rent, utilities, and janitorial services on the West Slope and in South Lake Tahoe, as well as indirect and overhead expenses, including clinical management, computing equipment and software licensing required to support the program.

Total program budget: $200,159

2010/11 ANNUAL UPDATE **EXHIBIT D**

PREVIOUSLY APPROVED PROGRAM

County: El Dorado

Program Number/Name: Program #7 - Health Disparities Initiative

Date: ~~September 28, 2010~~

Select one:

☐ **CSS**
☐ **WET**
☒ **PEI**
☐ **INN**

Prevention and Early Intervention				
No.	**Question**	**Yes**	**No**	
1.	Is this an existing program with no changes?	☐	☒	If yes, complete Exh. E4; If no, answer question #2
2.	Is there a change in the Priority Population or the Community Mental Health Needs?	☒	☐	If yes, completed Exh. F4; If no, answer question #3
3.	Is the current funding requested greater than15% of the previously approved amount?	☒	☐	If yes, complete Exh. F4; If no, answer question #4
4.	Is the current funding requested greater than 35% less of the previously approved amount?	☐	☒	If yes, complete Exh. F4; If no, answer questions 5, 5a, and 5b
5.	Describe the proposed changes to the Previously Approved Program and the rationale for those changes.			

This program will continue to target the priority population of the Latino population through use of the Promotora model, peer and family support, and group intervention strategies. The Native American population will be served under Program #5 – Wennem Wadati.

Health disparities (including the significant finding that individuals with serious mental illness have a life expectancy that is 25 years less compared to those without these diseases) affects populations with a range of characteristics – many of which are found among individuals suffering from mental distress. Access and utilization of services can serve as a first step toward the elimination of these disparities. Therefore, the proposed changes serve to include the following priority populations in this program by the provision of service pathways between behavioral health and primary health care providers and the use of Community Navigators to target these groups that experience disparities in access to healthcare services:

- At risk of homelessness;
- Adults with co-occurring disorders; and,
- Adults suffering from mental distress/mental illness with disparities of access to primary healthcare services.

A key element of this systems development approach includes the application of a community capacity building framework in which movement to natural supports enriches recovery, strengthens community, and enhances access to services.

5a.	If the total number of Individuals to be served annually is different than previously reported please provide revised estimates Total Individuals: __250__ Total Families: __250_		
5b.	If the total number of clients by type of prevention annually is different than previously reported please provide revised estimates:	**Prevention**	**Early Intervention**
	Total Individuals:	125	125
	Total Families:	125	125

Existing Programs to be Consolidated				
No.	**Question**	**Yes**	**No**	
1.	Is this a consolidation of two or more existing programs?	☐	☒	If yes, answer question #2; If no, answer questions for existing program above

*PEI Projects previously approved are now called Previously Approved Programs

PREVIOUSLY APPROVED PROGRAM

2.	Is there a change in the Priority Population or the Community Mental Health Needs?	☐	☐	If no, answer question #3; If yes, complete Exh. F4
3.	Will the consolidated programs continue to serve the same estimated number of individuals?	☐	☐	If yes, answer question #4; If no, complete Exh. F4
4.	Description of Previously Approved Programs to be consolidated. Include in your description: a) The names of Previously Approved programs to be consolidated, b) How the Previously approved programs will be consolidated; and c) Provide the rationale for consolidation			

*PEI Projects previously approved are now called Previously Approved Programs

2010/11 ANNUAL UPDATE **EXHIBIT F4**

PEI NEW PROGRAM DESCRIPTION

County: El Dorado

Program Number/Name: Program #7 – Health Disparities Initiative

Date: September 28, 2010

Instructions: Utilizing the following format please provide responses and refer to the instructions provided in the original PEI Guidelines, as noted in DMH Information Notices No.: 07-19 and 08-23. Complete this form for each new PEI Program and existing PEI Programs that made changes to Key Community Mental Health Needs, Priority Population, and/or funding as described in the Information Notice.

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
1. Disparities in Access to Mental Health Services	☒	☒	☒	☒
2. Psycho-Social Impact of Trauma	☒	☒	☒	☒
3. At-Risk Children, Youth and Young Adult Populations	☒	☒		
4. Stigma and Discrimination	☒	☒	☒	☒
5. Suicide Risk	☒	☒	☒	☒

2. PEI Priority Population(s) **Note: All PEI programs must address underserved racial/ethnic and cultural populations.**	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
1. Trauma Exposed Individuals	☒	☒	☒	☒
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☒	☒	☒	☒
3. Children and Youth in Stressed Families	☒	☒		
4. Children and Youth at Risk for School Failure	☒	☒		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☒	☒		
6. Underserved Cultural Populations	☒	☒	☒	☒

a. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s) and describe how the PEI program will reach/engage unserved and underserved multicultural communities.

The stakeholder input and data analysis for this program initiated during the CSS planning stage as this program was initially funded under CSS and then approved for funding under PEI in January 2010.

Community Program Planning Process
An extensive community outreach and planning process took place between February and October 2005 to identify the priority unmet mental health needs in the community.
In total, over 900 community members were consulted.

El Dorado County Mental Health conducted:

- 82 focus groups and MHSA trainings
- 23 interviews
- 5 written surveys resulting in 545 responses

In addition, 104 community representatives were involved in the workgroup planning process, including mental health consumers and their family members. In this comprehensive process, members representing a broad range of service providers were included in the workgroups and on the Advisory Committee, and updates were provided regularly to the Mental Health Commission.

Themes revealed through community outreach efforts

- A desire for community collaboration with County Mental Health.
- Safe and stable housing for transition age youth and adults who are mentally ill.
- Integrated services with substance abuse treatment facilities, schools, health facilities, and community agencies serving our target populations.

- Mental health treatment for the uninsured and underinsured, particularly children and older adults.
- Prevention of out-of-home placements for children and older adults.
- A need for case management.
- Access to concrete supports, such as housing, transportation, financial supports, employment and financial assistance that serve as barriers to service access.
- Improved outreach – particularly to the Latino community – to reduce stigma and discrimination that serve as barriers to accessing services.

Organizational Structure and Process
Community feedback, collaboration and planning were achieved in a variety of ways. Individual interviews, focus groups, MHSA trainings, and written surveys were used to inform community members and solicit feedback regarding the MHSA. Workgroups and writing teams reviewed the information and data and established recommendations for priority populations, model programs, and effective strategies. An Advisory Committee reviewed these proposals and, based on the community process, made recommendations to the Director of County Mental Health.

Community Planning Update and Lessons Learned
The goal of the El Dorado County Health Disparities Program is to collaborate with existing organizations and communities in the areas of outreach, engagement and provision of support services while adding the availability of culturally-relevant services for the underserved populations. Each of these strategies is intended to build on the strengths and self-determination of the community, families and individuals. Furthermore, there has been a growing understanding and perspective in relationship to the range of characteristics of the many groups impacted by stigma, discrimination, and disparities in service access. In addition, the lack of service integration as an added barrier has been increasingly voiced by community partners – particularly as resources in all areas of service delivery have declined. Finally, the absence of a sufficient safety net – particularly for those with co-occurring disorders (mental illness and substance abuse and/or mental illness and other chronic diseases) and homeless/at risk of homelessness– is a recurring theme in our community.

To begin to better address these issues, collaborative efforts to establish defined linkage mechanisms between behavioral healthcare providers, including substance abuse providers, and primary healthcare providers along with the support of Community Navigators to obtain these and other natural community supports is proposed under the PEI Health Disparities Initiative.

The identification of the priority populations and issues proposed to be served under this expanded Health Disparities Initiative resulted from the earlier CPP process (Latino Engagement Initiative) and the more recent CPP process (health disparities in access to behavioral health and physical healthcare services) as follows:

Latino Engagement Initiative (continuing program with no changes)

Community Mental Health Issue: Isolation and peer and family problems.

Priority Population(s): Over 600 Latinos in the target population are unserved.

Prevention Goal: Mental Health promotion and early intervention.

Desired Outcomes: Decreased mental distress and the related health indicators among the target population.

Identified strategy: Culturally-specific outreach, engagement, early identification of needs, service linkage, and peer and family prevention and early intervention strategies.

Establishment of Service Pathways between Behavioral Healthcare and Primary Care Providers

Community Mental Health Need: Disparity in life span experienced by adults with serious mental illness and insufficient safety net services for those with co-occurring disorders and at risk of homelessness.

Priority Population(s): Adults suffering from mental distress or mental illness, who lack a medical home and are affected by co-occurring disorders, and/or are at risk of homelessness.

Prevention Goal: Early identification of need for access to primary care for high risk adults who may be addressing multiple challenges (mental distress, co-occurring substance abuse problems, other chronic diseases, and/or unstable residence).

Desired Outcomes: Improved health status by means of access to behavioral health and/or physical healthcare services.

Identified strategy: Establishment of pathways for service access and use of Community Navigators to establish linkage

between behavioral healthcare and primary care providers, as well as natural community supports.

Each of these components will outreach, engage and link underserved populations by use of targeted strategies.

3. PEI Program Description (attach additional pages, if necessary).

This project, the **Health Disparities Initiative**, serves as a comprehensive outreach, engagement, service linkage, and early intervention strategy.

The previously approved component targets all ages of the Latino community, and therefore targets the following PEI target populations: *trauma exposed individuals, individuals experiencing onset of serious psychiatric illness, children and youth in stressed families, children and youth at risk for school failure and at risk of or experiencing juvenile justice involvement.* As a result, this program is intended to address the community mental health needs of *disparities in access to mental health services, psycho-social impact of trauma, at-risk children, youth and young adult populations, stigma and discrimination, and suicide risk.*

The former CSS-funded Health Disparities Initiative included contracted outreach and case management services for the Native American population. Under the approved PEI plan, Program #5 - Wennem Wadati – will serve this population.

Intervention Strategy/Model - Latino Engagement Initiative:
The goal of the El Dorado County Latino Engagement Initiative is to collaborate with existing agencies in the areas of outreach, engagement and provision of support services in order to build upon the strengths and self-determination of the Latino community, families and individuals, and to promote well-being by increasing access to healthcare services.

Desired Outcomes:
- Increased mental health service utilization by the Latino community.
- Decreased isolation which results from unmet mental health needs.
- Decreased peer and family problems which result from unmet mental health needs.

The MHSA vision for the Latino population in El Dorado County is one in which there is community awareness and understanding regarding mental illness and mental health thereby removing the stigma that creates barriers to service access. Further, the vision reflects an integrated system of service delivery that provides the necessary services and supports to successfully address all of the mental health needs of the Latino community. Finally, the hope is that outcomes, such as hopefulness, wellness, and self-efficacy, the meaningful use of time and capabilities, safe and adequate housing, and a network of supportive relationships, result from MHSA service use.

Two community-based agencies provide the services for this workplan – one in the Western Slope and another in South Lake Tahoe. In the Western Slope, the Promotoras (peer outreach workers) provide the majority of the services. Consistent with the Prevention Model, the agency findings were that proactive support served to alleviate symptoms of emotional distress and the need for more extensive services. In South Lake Tahoe, while the emphasis started with the provision of bicultural and bilingual mental health services, the effectiveness of psycho-education, support groups, and peer counseling initially for women, but later for men and for children emerged. In addition, Promotora outreach and engagement services are used to address barriers to healthcare access.

Behavioral Health and Primary Health Systems Linkage:
This new component is intended to build upon a local successful model of service integration, the Access El Dorado (ACCEL) Initiative's Care Pathways model. Care Pathways are a jointly developed series of shared, coordinated, and standardized steps/processes which are used by community health partners to bring about solutions to identified health challenges. Care Pathways currently in use within our County focus on helping individuals to: secure health insurance coverage; secure a medical home; use a medical home appropriately; access pediatric mental health services; and gain access to specialty care services. These cross-agency Pathways include step-by-step actions for obtaining the identified objective, resolving problems/barriers, and tracking outcomes.

Through this PEI plan, we are proposing to include pathways which facilitate linkage between behavioral health, primary care, and natural community supports, for adults faced with mental distress and co-occurring substance abuse or chronic disease issues, and/or are at-risk of homelessness. A key element of this systems development approach also includes an application of the community capacity building framework in which movement to natural supports enriches recovery, strengthens community, and enhances access to services. Specifically, we intend to develop a Pathway to ensure an effective two-way referral process relative to mental health services (for primary care clients that may need referral to County Mental Health's high level of specialty mental health services, or for stabilized County Mental Health clients that

become appropriate for referral to primary care for their psychiatric medication management, along with a lower level of behavioral health services available at a primary care setting such as a community health center/clinic). We also intend to develop a Pathway to ensure that clients who are appropriately receiving specialty mental health services from County Mental Health, are also referred to and properly using a primary care medical home to address other health issues. Ultimately, we'd like to develop additional Care Pathways/processes for improved integration of Mental Health, primary care, and alcohol/drug services. Once the proposed Pathways are developed and implemented, they will be available for use with multiple community health partners throughout our County.

Program start-up to establish new Pathways

BACKGROUND
The ACCEL Initiative is a community-wide collaborative whose purpose is to make El Dorado County a healthier community, especially within our vulnerable populations, by uniting, maximizing, connecting and focusing health resources. PEI funding is proposed to be used to leverage existing resources and expertise. To support the development of new Pathways described above, we intend to procure support from individuals with prior experience in developing, implementing, and using Care Pathways in El Dorado County. We also propose obtaining evaluation support services from the Sphere Institute, or a similar firm specializing in outcome evaluation.

The goals and objectives of ACCEL since its inception in 2002 were:

- To improve access to health care for individuals, particularly children, by developing an outreach, enrollment and retention program to assist individuals by enrolling them in low and no cost public health insurance. A second focus was to reduce the barriers to care for the publicly insured by increasing clinic capacity, expanding rural clinics, establishing a new FQHC, and developing a public network utilizing private physicians.

- To develop and implement cross-agency outcomes-based Care Pathways to resolve problems/barriers and track outcomes to improve health care. Through the use of Care Pathways, Referral Specialists, Community Health Workers (CHWs) and Mental Health Workers (MHWs) help individuals and families navigate health systems and agencies to ensure appropriate health care has been obtained and utilized (currently including one pathway to facilitate Pediatric Mental Health Consults).

- To improve the use of health information technology by implementing a software application (iREACH) used by Referral Specialists, CHWs, MHWs and other health care partners to track client progress through Care Pathways.

This project seeks to support a system development phase to expand the ACCEL care pathways to increase access and linkage for adults with behavioral healthcare and primary healthcare needs. Support from the ACCEL Care Pathways team (in areas of systems development, quality assurance, technical support, and professional involvement of the physician champions) will be leveraged. Inclusion of an evaluation component will be critical to measure the success of this pilot which is intended to ultimately be utilized with primary care providers throughout the community. Some areas of support are intended to be time limited for start-up purposes.

Use of Community Navigators
MHD staff will work collaboratively with the El Dorado County Community Health Center (a local FQHC), and other experienced resources, to develop and implement new Care Pathways specifically designed to improve health access and outcomes for adult clients with mental health needs. To support new Care Pathway design and implementation, we also propose funding staff within County Mental, as well as six months of dedicated staff (we anticipate a Clinical Social Worker, at approx. $48,000) within the El Dorado County Community Health Center. We are referring to these cross-agency staff as Community Navigators since, during Pathway implementation/use, they will help individuals navigate the Care Pathways medical systems/processes and will ensure that any problems/barriers to accessing appropriate services are resolved. They will also actively work with clients to promote related self-care behaviors and assist in identifying and obtaining other natural supports that may be available within our communities to promote client wellness and recovery. During the initial 6 months, it is anticipated that program start-up will require a higher level of systems development and implementation work and therefore time-limited funding is requested to support the active participation of these health partners. After initial development, the ongoing navigation will be related to supporting clients needing services.

Community Capacity Building and Access to Natural Supports
The Community Navigators will serve to both promote access to healthcare services as well as community natural supports. In this area, program start up will include partnering with Community Resource Center, various

community agencies and groups, and communities at large to identify community assets and resources and to mobilize movement toward linkage, integration and/or collaboration. The ability to access the community's natural supports is anticipated to both further client recovery while strengthening the community.

4. Activities

Activity Title	Proposed number of individuals or families through PEI expansion to be served through June 2011 by type of prevention:			Number of months in operation through June 2011
		Prevention	Early Intervention	
Latino Engagement	Individuals: Families:	50 50	50 50	12
Behavioral and Primary Healthcare Pathways	Individuals: Families:	25 25	25 25	6
	Individuals: Families:			
Total PEI Program Estimated Unduplicated Count of Individuals to be Served	Individuals: Families:			

5. Describe how the program links PEI participants to County Mental Health and providers of other needed services

To date, linkages for mental health treatment between the MHD and community-based providers has been occurring with varying levels of success. The goal of achieving a seamless and diverse system of care remains. The establishment of new pathways and the support of Community Navigators is intended to ensure that successful service linkage becomes a reality for adults that have unmet behavioral health and physical healthcare needs.

Linkage to culturally-specific services for the Latino, Native American, African American, and Asian populations, among others (including LGBT-specific services) is critical to effective PEI service delivery and these MHSA programs provide some valuable options (including the Community Education Program). However, additional research and networking will need to occur in order to address a broader range of racial and ethnic groups and other groups who experience disparities in access and outcomes. Outreach and engagement and the use of focus groups will be explored as part of an ongoing effort to do Community Program Planning for MHSA programs. Use of Community Navigators should also contribute constructively to a growing understanding of the diversity of community unmet needs.

6. Describe collaboration with and system enhancements of other partners such as community based organizations, schools, and primary care.

This program continues to provide mental health system enhancements by incorporating four community-based agencies: two that serve the Latino population under their MHSA contract, the local FQHC, and a new non-profit targeting individuals and families who are homeless. Furthermore, it facilitates increased integration between the Alcohol and Drug Programs under the Public Health Division and the Mental Health Division. This project will benefit from the working relationships that these agencies have with a range of service providers thereby further diversifying the reach of the mental health system.

Collaboration with community providers will occur at many levels: Information-sharing, referrals, collaborative service planning, and cross-training. On a client-by-client basis, collaboration may occur with a community-based organization (CBO) that provides culturally-specific services (including those integrated with the critical access points in the school and primary healthcare systems). Use of a prevention and early intervention model typically benefits from collaboration and linkage to natural resources within the client's community for ongoing support. The Health Disparities program providers serve as experts, consultants and trainers to this end and will assist in providing training for the MHSA PEI staff and others in cultural competence, use of interpreter services and cultural brokers, and resource brokerage, as well.

7. Describe intended outcomes.

The fundamental goals are to:

- Continue to provide a recognized and trusted access point for the Latino population relative to prevention and mental health services;
- Engage previously un-served or under-served individuals in need of mental health services;
- Provide identification, screening, referral and linkage to support services that will influence the determinants of health indicators, such as suicide.
- Provide support, education, and early intervention strategies that are culturally relevant and focused on building protective factors and decreasing risk factors;
- Reduce the barriers of stigma and discrimination among the Latino populations and others who are in need of behavioral healthcare needs integrated with other primary healthcare services;
- Decrease the disparity in mental health access among the Latino population; and,

- Increase behavioral health/primary care healthcare access for those experiencing signs of mental distress, co-occurring disorders, and/or those who are at-risk of homelessness.

High-risk populations to be targeted in this program include the Latino population of all ages and adults with behavioral healthcare and primary healthcare unmet needs. Targeted cultural goals and desirable outcomes include linkage with culturally-specific services, identification of culturally familiar support, and resources by which to recognize, return to, and celebrate cultural identity and traditions, and reduction of stigma and discrimination as barriers to integrated healthcare.

8. Describe coordination with Other MHSA Components.

Familiarity with the Health Disparities programs among CSS program staff exists. Improvement related to referral and communication mechanisms will be the focus on the upcoming year. The WET Coordinator will also look for opportunities to merge workforce development and the need for capacity building in the arena of prevention and health promotions in collaboration with the MHSA Project Coordinator. The other MHSA components are still under development.

9. Provide a budget narrative for costs identified for this Program, as outlined in Exhibit F. Please include the number of FTE personnel positions/classifications and a brief description of each FTE's functions. Please include a brief description of operating costs, subcontracts/professional services, and non-recurring expenditures associated with this PEI Program.

Funding for this project includes continuation of services originally included as part of the Latino Engagement Initiative:

- Personnel costs (salary, benefits and taxes) for a 0.1 FTE for a County Liaison / Utilization Review Coordinator: $12,772
- Subcontracted, professional services to provide preventative mental health services to the Latino population on the West Slope (WS) of El Dorado County and in South Lake Tahoe:
  - Family Connections (WS), $114,000
  - Family Resource Center (Tahoe), $149,409
- Educational materials and supplies, $2,227
- Facility costs, indirect and overhead expenditures of $6,856. Operating expenditures include costs allocated based on the former OMB A-87 Federal Register (now Title 2, Federal Regulations (CFR), Subtitle A, Chapter ii, Part 225), including facility expenses such as rent, utilities, and janitorial services, as well as other operating expenditures such as clinical management, computing equipment and software licensing.

The new components of this program (estimated to start in January 2011 and expected to be operational for 6 months of the fiscal year) include the following:

- Personnel expenditures to facilitate and implement the Behavioral Health and Primary Health Systems Linkage component, totaling $89,319
  - Psych Tech, 20 hours/week for 25 weeks (approximately 500 hours or 0.25 FTE)
  - Care Pathways/QA Manager, 16 hours/week for 25 weeks (approximately 400 hours or 0.2 FTE)
  - Community-based Mental Health Clinician, 40 hours a week for 25 weeks (approximately 1,000 hours or 0.5 FTE)
  - Additional 4 hours/week for 25 weeks (approximately 100 hours or 0.05 FTE) County Liaison / Utilization Review Coordinator
  - Medical Office Assistant 8 hours/week for 25 weeks (approximately 200 hours or 0.1 FTE)
  - Mental Health Program Coordinator at 4 hours/week for 25 weeks (approximately 100 hours or 0.05 FTE)
- Additional operating expenditures (as detailed above) in the amount of $62,675
- Subcontracted, professional services to develop and implement cross-agency outcomes-based Care Pathways and to mobilize movement toward linkage, collaboration and integration of physical and mental health services:
  - Care Pathways Physician Champion (MD in the role of Liaison/Advocate), $6,000
  - Program Evaluation Services for Care Pathways program, $5,000
  - Community Health Clinic, $48,000

Total program budget: $496,258

10. Additional Comments (Optional)

None.

County: El Dorado Date: 28-Sep-10

Program/Project Name and #: PEI #7 Health Disparities Initiative

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. EXPENDITURES				
Community Services and Supports				
1. Client, Family Member and Caregiver Support Expenditures				
a. Individual-based Housing				$0
b. Other Supports				$0
2. General System Development Housing				$0
3. Personnel Expenditures				$0
4. Operating Expenditures				$0
5. Estimated Expenditures when service provider is not known				$0
6. Non-recurring expenditures				$0
7. Other Expenditures*				$0
8. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Workforce Education and Training				
1. Personnel Expenditures				$0
2. Operating Expenditures				$0
3. Training Expenditures				$0
4. Training Consultant Contracts				$0
5. Residency Expenditures				$0
6. Internship Expenditures				$0
7. Mental Health Career Pathway Expenditures				$0
8. Stipend Funds				$0
9. Scholarship Funds				$0
10. Loan Repayment Funds				$0
11. Non-recurring Expenditures				$0
12. Other Expenditures*				$0
13. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Capital Facilities				
1. Pre-Development Costs				$0
2. Building/Land Acquisition				$0
3. Renovation				$0
4. Construction				$0
5. Repair/Replacement Reserve				$0
6. Other Expenditures*				$0
7. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Technological Needs				
1. Personnel				$0
2. Hardware				$0
3. Software				$0
4. Contract Services				$0
5. Other Expenditures*				$0
6. Total Proposed Expenditures	**$0**	**$0**	**$0**	**$0**
Prevention and Early Intervention (PEI)				
1. Personnel	$102,091		$311,409	$413,500
2. Operating Expenditures	$71,758			$71,758
3. Non-recurring Expenditures				$0
4. Subcontracts/Professional Services			$11,000	$11,000
5. Other				$0
6. Total Proposed Expenditures	**$173,849**	**$0**	**$322,409**	**$496,258**

Innovation (INN)						
	1. Personnel					$0
	2. Operating Expenditures					$0
	3. Non-recurring Expenditures					$0
	4. Training Consultant Contracts					$0
	5. Work Plan Management					$0
	6. Other					$0
	7. Total Proposed Expenditures		**$0**	**$0**	**$0**	**$0**
B. REVENUES						
	1. New Revenues					
	a. Medi-Cal (FFP only)					$0
	b. State General Funds					$0
	c. Other Revenue					$0
	2. Total Revenues		**$0**	**$0**	**$0**	**$0**
C. TOTAL FUNDING REQUESTED			**$173,849**	**$0**	**$322,409**	**$496,258**

***Enter the justification for items that are requested under the "Other Expenditures" category.**

Justification:

Please include your budget narrative on a separate page.

Prepared by: Janet Stevens

Telephone Number: (530) 621-6226

PEI NEW PROGRAM DESCRIPTION EXHIBIT F cont.
BUDGET NARRATIVE

Action #7 – Health Disparities

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The new components of this program (estimated to start in January 2011 and expected to be operational for 6 months of the fiscal year) include the following:

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  - Care Pathways Physician Champion (MD in role of Liaison/Advocate), $6,000
  - Program Evaluation Services for Care Pathways program, $5,000
  - Community Health Clinic, $48,000

Total program budget: $496,258

FY 2010/11 **EXHIBIT E4**

PEI BUDGET SUMMARY

County: El Dorado **Date:** 9/28/2010

	PEI Programs		FY 10/11 Requested MHSA Funding	Estimated MHSA Funds by Type of Intervention		Estimated MHSA Funds by Age Group				
	No.	Name		Prevention	Early Intervention	Children and Youth	Transition Age Youth	Adult	Older Adult	
Previously Approved Programs										
1.	1	Early Intervention Program for Youth	$319,768	$0	$319,768	$127,908	$127,907	$47,965	$15,988	
2.	5	Wennem Wadati - A Native Path to Healing	$116,865	$99,335	$17,530	$23,373	$46,746	$23,373	$23,373	
3.			$0							
4.			$0							
5.			$0							
6.			$0							
7.			$0							
8.			$0							
9.			$0							
10.			$0							
11.			$0							
12.			$0							
13.			$0							
14.			$0							
15.			$0							
16.	Subtotal: Programs*		$436,633	$99,335	$337,298	$151,281	$174,653	$71,338	$39,361	Percentage
17.	Plus up to 15% County Administration		$65,495							15.0%
18.	Plus up to 10% Operating Reserve		$50,213							10.0%
19.	Subtotal: Previously Approved Programs/County Admin./Operating Reserve		$552,341							
New Programs										
1.	2	Primary Intervention Project (PIP)	$237,830	$237,830	$0	$237,830	$0	$0	$0	
2.	3	Incredible Years	$155,777	$155,777	$0	$116,833	$0	$31,155	$7,789	
3.	4	Community Education Project	$69,109	$69,109	$0	$17,277	$17,277	$17,278	$17,277	
4.	6	Wellness Outreach Program (WOP)	$200,159	$160,127	$40,032	$0	$20,016	$80,064	$100,079	
5.	7	Health Disparities Initiative	$496,258	$248,129	$248,129	$124,065	$124,064	$124,065	$124,064	
6.	Subtotal: Programs*		$1,159,133	$870,972	$288,161	$496,005	$161,357	$252,562	$249,209	Percentage
7.	Plus up to 15% County Administration		$173,870							15.0%
8.	Plus up to 10% Operating Reserve		$133,300							10.0%
9.	Subtotal: New Programs/County Admin./Operating Reserve		$1,466,303							
10.	**Total MHSA Funds Requested for PEI**		$2,018,644							

*Majority of funds must be directed towards individuals under age 25. Percent of funds directed towards those under 25 years = 62%

Note: Previously Approved Programs that propose changes to Key Community Health Needs, Priority Populations, and/or funding as described in the Information Notice are considered New.

Exhibit I

Training, Technical Assistance and Capacity Building Funds Request Form (Prevention and Early Intervention Statewide Project)

x Previously approved with no changes

☐ New

Date: September 28, 2010	County Name: El Dorado
Amount Requested for FY 2010/11: $ 21,700	

A. Briefly describe your plan for using the Training, Technical Assistance and Capacity Building funding and indicate (if known) potential partner(s) or contractor(s).

El Dorado County Health Services Department (HSD) staff and community members have recently participated in a MHSA-funded and CIMH-sponsored Learning Collaborative on Capacity Building Strategies with consultants John Ott and Rose Pinard. The community is, therefore, in the early stages of identifying a strategic plan to operationalize this framework.

Capacity to do even this critically important step is a challenge at this time. Yet, there is a core group of tremendously committed HSD and community members who are continuing to meet to carry the momentum forward.

Critical elements that require support in order to engage in continued learning related to this model include networking with other counties engaged in this process and the continued use of the consultants. Further, it is anticipated that a structure by which to incorporate a broader range of County partners in the process is an important goal and these funds will be used, therefore, in part to this end.

The HSD will also leverage the State funding for the Capacity Building Learning Collaborative to ensure that the local County funds are used in the most efficient and effective manner.

B. The County and its contractor(s) for these services agree to comply with the following criteria:

1) This funding established pursuant to the Mental Health Services Act (MHSA) shall be utilized for activities consistent with the intent of the Act and proposed guidelines for the Prevention and Early Intervention component of the County's Three-Year Program and Expenditure Plan.
2) Funds shall not be used to supplant existing state or county funds utilized to provide mental health services.
3) These funds shall only be used to pay for the programs authorized in WIC Section 5892.
4) These funds may not be used to pay for any other program.
5) These funds may not be loaned to the state General Fund or any other fund of the state, or a county general fund or any other county fund for any purpose other than those authorized by WIC Section 5892.
6) These funds shall be used to support a project(s) that demonstrates the capacity to develop and provide statewide training, technical assistance and capacity building services and programs in partnership with local and community partners via subcontracts or other arrangements to assure the appropriate provision of community-based prevention and early intervention activities.
7) These funds shall be used to support a project(s) that utilizes training methods that have demonstrated the capacity to increase skills and promote positive outcomes consistent with the MHSA and PEI proposed guidelines.

Certification

I HEREBY CERTIFY to the best of my knowledge and belief this request in all respects is true, correct, and in accordance with the law.

_____

Director, County Mental Health Program (original signature)